

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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08250

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08238

1. PLACE OF DEATH o. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER RT#5		c. LENGTH OF STAY IN TB 4 YRS.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER RD#506-1		d. STREET ADDRESS SPRINGDALE ROAD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRINGDALE ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BERTHA IRENE (RUBY) ALBERT		4. DATE OF DEATH Month JUNE Day 11 Year 1966	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 18 1899
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE (WORKED IN CANNING FACTORY)		10b. KIND OF BUSINESS OR INDUSTRY FRED. CO. MD	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES HAINES		14. MOTHER'S MAIDEN NAME EMMA MAE FRITZ	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 220-10-6643	
17. INFORMANT Walter J. Albert		Address WESTMINSTER MD-1 RD#5	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Seen by Dr. Glen Sprecher on 5/24/66 DUE TO (c) on 5/24/66		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic CVD		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/2/64 , 19__ to 6/11/66 , 19__, that (I) (we) lost saw the deceased alive on 12/2/64 19__, and that death occurred at 4:20 P.M. from causes on and on the date stated above.			
22a. SIGNATURE M.E. Robertson		22b. DATE SIGNED 6/11/66	
22c. PHYSICIAN'S NAME (Type) M.E. ROBERTSON M.D.		22d. ADDRESS New Windsor, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/14/66	
23c. NAME OF CEMETERY OR CREMATORY LOCUST GROVE CEM.		23d. LOCATION (City or Town) (County) (State) UNIONVILLE, FRED CO. MD.	
24. FUNERAL DIRECTOR J. S. Myers Jr., Westminster, Md.		25a. REC'D BY REGISTRAR JUN 14 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

08380

STATE OF TEXAS

08380

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 11/11/01 BY 60322 UCBAW/MLP

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08251

CERTIFICATE OF DEATH

08239

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 5 mos. 6 dys. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 11802 Georgia Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BESSIE (nmn) BARANSKI		4. DATE OF DEATH Month Day Year June 8 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-21-94
9. AGE (In years lost birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	11. BIRTHPLACE (County & State, or foreign country) Poland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Steven Augustofski	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Records, Springfield State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart failure DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction.		INTERVAL BETWEEN ONSET AND DEATH days days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20a. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20e. (City or town)	20f. (County)	20g. (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-2-66 , 19____, that (I) (we) last saw the deceased alive on 6-8-66 , 19____, and that death occurred at 12:00 noon , 19____, from causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo. M.D. 22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22b. DATE SIGNED 6-8-66 22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 6-11-66	23c. NAME OF CEMETERY OR CREMATORY St. Ladislaus Cemetery	23d. LOCATION (City or Town) (County) (State) Allegany Co. PA.
24. FUNERAL DIRECTOR Harry W. Haight Sykesville, Md.		25. REC'D BY REGISTRAR JUN 10 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08252

08240

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY in 1b <u>1 day</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster R.T. #5</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Co. General Hospital</u>			d. STREET ADDRESS <u>Arundale</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ORA</u> Middle <u>MAY</u> Last <u>BEACHAM</u>			4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>1966</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 27 1898</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William Thomas Surfe</u>			14. MOTHER'S MAIDEN NAME <u>Millie Annison</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u>217-36-4352</u>	17. INFORMANT <u>P. Shingluff Beacham</u> Address <u>Same</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL FAILURE</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>MONTHS</u> <u>YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>UREMIA</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) <u></u>	(County) <u></u>	(State) <u></u>
21. I certify that (I) (this hospital) attended the deceased from <u>6/26</u> , 19 <u>66</u> , to <u>6/27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6/26</u> , 19 <u>66</u> , and that death occurred at <u>12:30</u> P.M. from causes and on the date stated above.					
22a. SIGNATURE <u>Vincent J. Kuroda Jr.</u>			22b. DATE SIGNED <u>6/27/66</u>		
22c. PHYSICIAN'S NAME (Type) <u></u>			22d. ADDRESS <u></u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/29/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Memorial Gardens</u>	23d. LOCATION (City or Town) <u>Stimberton, Md.</u>	(County) (State)	
24. FUNERAL DIRECTOR <u>L.S. Myers, Jr.</u>			25a. REC'D BY REGISTRAR DATE <u>JUN 30 1966</u>		
			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

08840

CERTIFICATE OF DEATH

08840

NAME: *James P. Gifford*
DATE OF BIRTH: *1912*
PLACE OF BIRTH: *St. Louis, Mo.*
DATE OF DEATH: *May 1968*
PLACE OF DEATH: *St. Louis, Mo.*

CAUSE OF DEATH: *Myocardial Infarction*

DATE OF DEATH: *May 1968*

AGE: *56*

SEX: *Male*

EDUCATION: *High School Graduate*
OCCUPATION: *Engineer*
MARRIAGE: *Married*

PREVIOUS ILLNESS: *None*
TREATMENT: *None*
HISTORY: *None*

DIAGNOSIS: *Myocardial Infarction*
PATHOLOGIC FINDINGS: *None*

TESTS: *None*
X-RAY: *None*
LABORATORY: *None*

POSTMORTEM: *None*
BURIAL: *None*
FUNERAL: *None*

SIGNATURE: *James P. Gifford*
DATE: *May 1968*

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH															
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
08253					CERTIFICATE OF DEATH					08241					
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster			c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown					03-2					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Co., General Hospital					d. STREET ADDRESS 906 Shirley Manor Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) EVA F. BEALL					First Middle Last		4. DATE OF DEATH June 18, 1966			Month Day Year					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH March 17, 1904		9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME William D. Butler					14. MOTHER'S MAIDEN NAME Elsie M. Bair										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 216-07-0624		17. INFORMANT George R. Beall Same as # 2					Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial asthma, severe										INTERVAL BETWEEN ONSET AND DEATH 2 weeks					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from June 9, 1966 to June 18, 1966 , that (I) (we) last saw the deceased alive on June 18, 1966 , and that death occurred at 6:56 P.M. from causes and on the date stated above.															
22a. SIGNATURE John S. Harshey					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/18/66								
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY					22d. ADDRESS 8 Anchor St. Westminster, Md										
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 6-21-1966		23c. NAME OF CEMETERY OR CREMATORY St. James			23d. LOCATION (City or Town) (County) (State) Carroll Co., Maryland							
24. FUNERAL DIRECTOR C.M. Waltz, Box 241, Sykesville, Md.					ADDRESS		25a. REC'D BY REGISTRAR JUN 21 1966			25b. REGISTRAR'S SIGNATURE J Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>				c. LENGTH OF STAY IN 1b <u>1 yr.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural, Westminster</u> <u>06-1</u>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>73 Manchester Ave</u>						d. STREET ADDRESS <u>73 Manchester Ave</u>					
3. NAME OF DECEASED (Type or print) <u>ANNA</u> First <u>MABEL</u> Middle <u>BEAVER</u> Last						4. DATE OF DEATH Month <u>JUNE</u> Day <u>2</u> Year <u>1966</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 13, 1907</u>		9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>59</u> Days <u>59</u> Hours <u>59</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house-wife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co. Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Clayton S. Groat</u>						14. MOTHER'S MAIDEN NAME <u>Bertie Youngling</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>219-12-1102</u>		17. INFORMANT Address <u>73 Manchester Ave</u> <u>M. Floyd Beaver, Westminster Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Cardiovascular dis. with Hypertension</u> (c) <u>2 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none, but obesity</u> INTERVAL BETWEEN ONSET AND DEATH <u>11 hours</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 13, 1907</u> to <u>6-2-66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6-1-66</u> , 19 <u>66</u> , and that death occurred at <u>5:20 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>C. H. Billingslea</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>6-2-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>C. H. Billingslea</u>						22d. ADDRESS <u>Westminster, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>6/4/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Westminster, Md.</u>		
24 FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr.</u> ADDRESS <u>Westminster, Md.</u>						25a. REC'D BY REGISTRAR <u>JUN 3 1966</u>			25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>		

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08255

CERTIFICATE OF DEATH

08243

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3 weeks	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		d. STREET ADDRESS Shipes Lane	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pullen Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sadie Middle F. Last Berryman		4. DATE OF DEATH Month 6 Day 26 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1881
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Balto. City		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David E. Little		14. MOTHER'S MAIDEN NAME Mary M. Scharf	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr Gilbert M. Berryman		Address Kenmar Ave Garrison P.O. Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4330 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis C.V.D. DUE TO (c) Heart Block			INTERVAL BETWEEN ONSET AND DEATH 15 min. 15 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 17, 1966 to June 26, 1966 , that (I) (we) last saw the deceased alive on June 18, 1966 , and that death occurred at 4:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Sani Okutman M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 6.27.66
22c. PHYSICIAN'S NAME (Type) Dr. A. Sani Okutman		22d. ADDRESS Obrecht Rd Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/29/66	23c. NAME OF CEMETERY OR CREMATORY Lakeview Memorial	23d. LOCATION (City or Town) (County) (State) Carroll Md.
24. FUNERAL DIRECTOR Strong Byers		25a. REC'D BY REGISTRAR DATE JUN 30 1966	
25b. REGISTRAR'S SIGNATURE Randall		25c. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08543

CERTIFICATE OF DEATH

08543

NAME

MR.

NAME

DATE OF BIRTH

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

TIME OF DEATH

CAUSE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

DATE OF INTERMENT

DATE OF INTERMENT

PLACE OF INTERMENT

PLACE OF INTERMENT

DATE OF BURIAL

DATE OF BURIAL

PLACE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

DATE OF CREMATION

PLACE OF CREMATION

PLACE OF CREMATION

DATE OF EXHUMATION

DATE OF EXHUMATION

PLACE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

PLACE OF REINTERMENT

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PLACE OF REINTERMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08256

CERTIFICATE OF DEATH

08244

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 305 S. Eden Street	
3. NAME OF DECEASED (Type or print) First Rose Middle - Last Billitz		4. DATE OF DEATH Month 6 Day 26 Year 1966	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown
9. AGE (In years last birthday) 63?		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		12. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Isaac Elsasser		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Springfield Hospital records, Sykesville		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) M. abdominal 2865 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, hebephrenic type.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from 4/14/1961 , to 6/26 , 19 66 , that it (we) lost the deceased alive on 6/26 , 19 66 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE Hassan A. Salih		22b. DATE SIGNED 6/26/66	
22c. PHYSICIAN'S NAME (Type) Hassan A. Salih, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/30/66	
23c. NAME OF CEMETERY OR CREMATORY mt Carmel		23d. LOCATION (City or Town) (County) (State) Balta, Md	
24. FUNERAL DIRECTOR Sylvan S. Lima Son 3319 Olympia Ave		25a. REC'D BY REGISTRAR JUL 5 1966	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

1234

1998

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08257

CERTIFICATE OF DEATH

08245

1. PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>43 Yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		d. STREET ADDRESS <u>125 Washington Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Co. General Hospt.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ERMA JENNINGS BONSACK</u>		4. DATE OF DEATH Month Day Year <u>JUNE 28 19 66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 20, 1897</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Frederick, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William M. Bopst</u>		14. MOTHER'S MAIDEN NAME <u>ANNA MARY Brunner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>220-28-8380</u>	
17. INFORMANT <u>Mr. J. Ralph Bonsack</u>		Address <u>same address</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Vascular Insufficiency</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 12, 19 66</u> , to <u>June 28, 19 66</u> , that (I) (we) last saw the deceased alive on <u>June 28, 19 66</u> , and that death occurred at <u>1:40</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Harshey</u>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>6/28/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY</u>	22d. ADDRESS <u>8 Avalon St. Westminster, Md</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6/30/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Meadow Branch</u>	23d. LOCATION (City or Town) (County) (State) <u>Rural Westminster, Md</u>
24. FUNERAL DIRECTOR <u>J. E. Myers, Jr. Westminster, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 30 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

250-28-2280 Mr. J. Ralph Bonack
 250-28-2280 Mr. J. Ralph Bonack
 250-28-2280 Mr. J. Ralph Bonack

William M. Bonack
 Anna Mary Bonack
 250-28-2280 Mr. J. Ralph Bonack

Frank White
 Horse wife
 Frederick R. M.D. 11-20

Frank White
 Horse wife
 Frederick R. M.D. 11-20

Frank White
 Horse wife
 Frederick R. M.D. 11-20

Frank White
 Horse wife
 Frederick R. M.D. 11-20

Frank White
 Horse wife
 Frederick R. M.D. 11-20

Frank White
 Horse wife
 Frederick R. M.D. 11-20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

08255		MARYLAND STATE DEPARTMENT OF HEALTH		08246	
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND					
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester, Md.</u> c. LENGTH OF STAY IN 1b <u>7 hrs 2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Longview Nursing Home Manchester, Md.</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baths</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lower Buckhleyville Rd, Hampstead Md</u> d. STREET ADDRESS <u>128 N Main St</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Joseph</u> First Middle Last 4. DATE OF DEATH <u>6-29-66</u> Month Day Year			5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 6, 1891</u> 9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Cockeysville, Md. Balt Co.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Thomas C. Bosley</u> 14. MOTHER'S MAIDEN NAME <u>Alice Roberta Sanders</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>212-32-4283</u> 17. INFORMANT <u>Joseph Bosley Jr. Son</u> Address <u>Lower Buckhleyville Rd, Hampstead Md</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>177X</u> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CA Prostate</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>2 U. infected ms.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from <u>March 1</u> , 19 <u>66</u> to <u>6/29</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6/29</u> , 19 <u>66</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>C. H. Houghton</u> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <u>Greenmount Md</u> 22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>7/2/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Bosley's Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Sparks Md.</u>			24. FUNERAL DIRECTOR <u>Tipton-Eline</u> ADDRESS <u>Hampstead, Md</u> 25a. REC'D BY REGISTRAR <u>J. Charles Judge</u> 25b. REGISTRAR'S SIGNATURE DATE <u>JUL 5 1966</u>		

00322

00310

THE STATE OF NEW YORK

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08253

08247

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL - Sykesville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL Sykesville 06-1</u>	
c. LENGTH OF STAY IN 1b <u>Years</u>		d. STREET ADDRESS <u>Liberty Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Liberty Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MINNIE EDNA BURTON</u> First Middle Last		4. DATE OF DEATH <u>June 28 1966</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 23, 1892</u>
9. AGE (In years last birthday) <u>74 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housew. fe</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Kidwell</u>		14. MOTHER'S MAIDEN NAME <u>Orpha Shipley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Mr. Richard Burton - Sykesville, Md.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Infarction</u> <u>4201</u> DUE TO (b) <u>Arterio-Sclerotic C.V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Maurice C. Porterfield</u>		22. DATE SIGNED <u>6-28-66</u>	
EXAMINER'S NAME (Type) <u>MAURICE C. PORTERFIELD</u>		23. DATE SIGNED <u>6-28-66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-30-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>BALTO. Md.</u>	
24. FUNERAL DIRECTOR <u>Harry W. Haight</u> ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		DATE <u>JUL 1 1966</u>	

1527

2000

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08260

08248

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. LENGTH OF STAY IN 1b 2mo. 6days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bessie Middle (NMN) Last Call		4. DATE OF DEATH Month 6 Day 20 Year 1966	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/5/02
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William T. Johnson		14. MOTHER'S MAIDEN NAME Frances Fasenbaker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-46-1628	
17. INFORMANT Springfield Hospital records, Sykesville		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Decubitus ulcers DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome with circulatory disorder (CVA) with psychotic reaction and residual schizophrenia.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/14/1966 to 6/20/1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 6/20/1966 , and that death occurred at 6:05 PM , from causes and on the date stated above.			
22a. SIGNATURE Edmee J. Reeves		22b. DATE SIGNED 4/21/66	
22c. PHYSICIAN'S NAME (Type) Edmee J. Reeves, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-25-66	
23c. NAME OF CEMETERY OR CREMATORY Freedom Cemetery		23d. LOCATION (City or Town) (County) (State) Sykesville Md.	
24. FUNERAL DIRECTOR Harvey W. Haight		25. REC'D BY REGISTRAR JUN 27 1966	
ADDRESS Sykesville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08261

CERTIFICATE OF DEATH

08249

1. PLACE OF DEATH a. COUNTY Carroll Maryland MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville		c. LENGTH OF STAY IN 1b 0yr. 2mo. 15da.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville Rt. #3 Box 136			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS --	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elbert (NMN) Carroll, Sr		4. DATE OF DEATH Month 6 Day 24 Year 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10-11-74
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Carroll		14. MOTHER'S MAIDEN NAME Hanna -- (Carroll)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) none		16. SOCIAL SECURITY NO. 219-10-3240	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia 4200 DUE TO arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) Senile brain disease DUE TO (c) Senile brain disease		INTERVAL BETWEEN ONSET AND DEATH 5 days years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome, associated with cerebral arterio-sclerosis without qualifying phrase.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. -- 79		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --		20f. (City or town) (County) (State) --	
21. I certify that (a) (this hospital) attended the deceased from 4-9- , 19 66 to 6-24 , 19 66 , that (b) (we) last saw the deceased alive on 6-24 , 19 66 , and that death occurred at 9 A. M., from causes and on the date stated above.			
22a. SIGNATURE Moises Sucholeiki		22b. DATE SIGNED 6-24-66	
22c. PHYSICIAN'S NAME (Type) Moises Sucholeiki, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 6-27-66	23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	23d. LOCATION (City or Town) (County) (State) Cecilton, Md.
24. FUNERAL DIRECTOR Nancy W. Haight Sykesville, Md.		25a. REC'D BY REGISTRAR DATE JUN 27 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The plates remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FEDERAL BUREAU OF INVESTIGATION

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Baltimore

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Taneytown					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Taneytown						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS						
3. NAME OF DECEASED (Type or print) Ruby Ida CROUSE					4. DATE OF DEATH June 17 1966						
5. SEX F		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 31, 1890		9. AGE (in years last birthday) 76 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Wilson L. Crouse					14. MOTHER'S MAIDEN NAME Carrie Ruby						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. 216-46-8015		17. INFORMANT Mrs. Robert Angell, Taneytown, Maryland			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Coronary Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH Unknown	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE Maurice C. Porterfield EXAMINER'S NAME (Type) Maurice C. Porterfield					CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Hampstead, Md.					22. DATE SIGNED 6-17-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF June 20, 1966		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery			23d. LOCATION (City, town or county) (State) Taneytown, Maryland			
24. FUNERAL DIRECTOR John H. Skiles C.O. Fuss & Son (John H. Skiles) Taneytown, Md.					25a. REC'D BY REGISTRAR JUN 20 1966		25b. REGISTRAR'S SIGNATURE Charles Judge				

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08263

CERTIFICATE OF DEATH

08251

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville				c. LENGTH OF STAY IN 1b 2y. 10m. 2d.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First May Middle Blanche Last Curry				4. DATE OF DEATH Month June Day 25 Year 1966			
5. SEX female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 14, 1985	
9. AGE (In years last birthday) 81 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME William Ross			
14. MOTHER'S MAIDEN NAME Ervin, Martha				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			
16. SOCIAL SECURITY NO. ---				17. INFORMANT Springfield Hospital records, Sykesville Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE 260X DUE TO ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS associated with cerebral arteriosclerosis with psychotic reaction							INTERVAL BETWEEN ONSET AND DEATH 1 yrs.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 8/23 , 19 63 , to 6/25 , 19 66 , that (X) (we) last saw the deceased alive on 6/25 19 66 , and that death occurred on 11:45AM from causes and on the date stated above.							
22a. SIGNATURE <i>Dr. B. B. B. B. B.</i>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) DR. B. B. B. B. B.	
22d. ADDRESS Springfield State Hospital				22e. ADDRESS Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF June 28, 1966		23c. NAME OF CEMETERY OR CREMATORY St. Zion Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR Joseph H. Russ				25a. REC'D BY REGISTRAR JUN 29 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08881

08883

NAME	LAST	FIRST	MIDDLE	SUFFIX
SMITH	JOHN	DAVID	WILLIAM	JR
DATE OF BIRTH	1945	05	15	
PLACE OF BIRTH	NEW YORK	CITY	STATE	NY
EDUCATION	HIGH SCHOOL	DIPLOMA	DEGREE	
EMPLOYMENT	MANUFACTURING	INDUSTRY	POSITION	WORKER
RESIDENCE	123	STREET	CITY	STATE
ZIP CODE	10001			
TELEPHONE	212	555	1234	
RELIGION	PROTESTANT			
MARRIAGE	MARRIED	DATE	1968	
SPOUSE	JANE	SMITH		
CHILDREN	2			
REMARKS	ALL INFORMATION ON THIS CARD IS UNCLASSIFIED			
DATE	1980	01	15	
BY	JOHN	DAVID	WILLIAM	SMITH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BP

MEDICAL CERTIFICATION

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
08264 Item 2 Film C-78 1721/66 mm		08252 Item 7 Film C-78 778/66 mm									
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MD</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Woodbury</u>				c. LENGTH OF STAY IN 1b <u>8 mo</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WADSWORTH / Baltimore</u> 17 30-4					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Golden Age Guest Home</u>						d. STREET ADDRESS <u>1802 Eutaw Pl.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Pearl</u> First <u>Nashell</u> Middle <u>-</u> Last						4. DATE OF DEATH <u>June 30-66</u> Month <u>30-66</u> Day <u>1966</u> Year					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>11-25-00</u>		9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>MD</u>	
13. FATHER'S NAME <u>UNKNOWN</u>						14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-20-8720</u>		17. INFORMANT <u>Guest Home Records</u>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Concurrent Cardiac Involvement</u> <u>4222</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chr. Myocarditis</u> (c) <u>Hypertrophy of Left Ventricle</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 13 1963</u> to <u>June 30 1966</u> that (I) (we) last saw the deceased alive on <u>June 29 1966</u> and that death occurred at <u>4:50 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>M. H. Martin</u>						22b. PHYSICIAN'S NAME (Type) <u>M. H. Martin</u>		22c. DATE SIGNED <u>12/30/66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>7-2-66</u>						23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEMORIAL</u>		23d. LOCATION (City, town or county) (State) <u>BALTO MD</u>	
24. FUNERAL DIRECTOR <u>C. F. Evans + Son 8802 NORTON RD</u>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUL 5 1966</u>	

08380

08380

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
08265		08253									
1. PLACE OF DEATH a. COUNTY <u>Woodbine</u> <u>Carroll Co.</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HOWARD</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODBINE</u>				c. LENGTH OF STAY IN 1b <u>1 1/2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.F.D. LAUREL</u> <u>13-2</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Golden Age Hunt Home</u>						d. STREET ADDRESS <u>1600 Scaggsville Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lillian</u> <u>DEAN</u>						4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 17, 1898</u>		9. AGE (in years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>WALTER W. JONES</u>						14. MOTHER'S MAIDEN NAME <u>FLORENCE E. LOWE</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-30-8559</u>		17. INFORMANT <u>Mrs. Lillian Huber, same as #2</u>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>350X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Parkinson Disease</u> DUE TO (c) <u>Metabolic deficiency</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>18 yrs</u> <u>8</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 16, 1965</u> , to <u>June 12, 1966</u> , that (I) (we) last saw the deceased alive on <u>June 12, 1966</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>H. H. Harton</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>June 13-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>H. H. HARTON</u>						22d. ADDRESS <u>Hartmonster, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>June 16, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bethesda Methodist Church</u>		23d. LOCATION (City, town or county) (State) <u>Cen. Eldersburg, Maryland</u>					
24. FUNERAL DIRECTOR <u>Harold S. Wade, 550 Wash. Blvd, Laurel, Maryland</u>						25a. REC'D BY REGISTRAR <u>JUN 16 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

FISHER

28590

10

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
SM 1/65

08266

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08254

1. PLACE OF DEATH a. COUNTY <i>CARROLL</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>CARROLL</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>		c. LENGTH OF STAY IN ID <i>2 hours</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>CARROLL CO. GENERAL HOSPITAL</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>FINKSBURG, MD</i>	
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>Dayid</i> Last <i>DICKERSON</i>		4. DATE OF DEATH Month <i>JUNE</i> Day <i>12</i> Year <i>1966</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 7, 1916</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>TRUCK DRIVER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Montgomery Wards</i>	9. AGE (In years last birthday) <i>49</i> yrs.
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Arthur Dickerson</i>		14. MOTHER'S MAIDEN NAME <i>Millie Jane ?</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>215-12-1728</i>	
17. INFORMANT <i>Mrs. Lelia May Dickerson</i>		Address <i>Deer Park Rd. Finksburg, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> 4201 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>3 hours</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Maurice C. Porterfield</i> EXAMINER'S NAME (Type)		22. DATE SIGNED <i>6/12-66</i> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>HANOVER, MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>June 15, 66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Lake View Mem. Park</i>	23d. LOCATION (City, town or county) (State) <i>Sykesville, Carroll Co. Md.</i>
24. FUNERAL DIRECTOR <i>H. J. Schacht</i> ADDRESS <i>Owings Mills, Maryland</i>		25a. REC'D BY REGISTRAR <i>JUN 16 1966</i> 25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

522

2420

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
08267		08255							
1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Sykesville c. LENGTH OF STAY IN 1b 3 yr 7mo 23d d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 606 N. Castle Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Lillie Mae Dominick		4. DATE OF DEATH Month 6 Day 28 Year 1966							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 - 1 - 82		9. AGE (In years last birthday) 84 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Frederick Morgenroth				14. MOTHER'S MAIDEN NAME Cornelia Hahn					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Springfield Hospital records, Sykesville, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS associated with senile brain disease with psychotic reaction									INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (b) (this hospital) attended the deceased from 11-5 , 19 62 , to 6/28 , 19 66 , that (M) (we) last saw the deceased alive on 6/28 19 66 , and that death occurred at 7:00 PM from the causes and on the date stated above.									
22a. SIGNATURE <i>Naci N. Buyukunsal</i>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M.D.			
22d. ADDRESS Springfield State Hospital Sykesville, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/30/66		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane				25a. REC'D BY REGISTRAR JUN 30 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MEDICAL CERTIFICATION

2000

253

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
08268 CERTIFICATE OF DEATH 08256											
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u>				c. LENGTH OF STAY IN 1b <u>Weeks</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Woodbine - Rural</u> 13-2					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Woodbine - Rural</u>						d. STREET ADDRESS <u>Route 1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ethel</u>			First <u>D.</u> Middle <u>Duwall</u> Last			4. DATE OF DEATH <u>June 3, 1966</u>			Month <u>June</u> Day <u>3</u> Year <u>1966</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 1, 1912</u>		9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>53</u> Days <u>53</u> Hours <u>53</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pants Factory</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Howard Co., Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Herbert Crabb</u>						14. MOTHER'S MAIDEN NAME <u>Rosie Wetzel</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-07-4822</u>		17. INFORMANT <u>Mr. Willard Duwall Woodbine, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach lining,</u> <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>liver involvement, anemia -</u> DUE TO (c) <u>Cardiac arrest</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1964</u> <u>6-3-66</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u>64</u> , to <u>6-3</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6-3</u> , 19 <u>66</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Howard E. Hall</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall</u>						22d. ADDRESS <u>Sykesville, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>6/7/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Morgan Chapel Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Carroll Co., Md.</u>			
24. FUNERAL DIRECTOR <u>C. M. Waltz</u>						ADDRESS <u>Box 241 Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Carroll</i>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>				c. LENGTH OF STAY IN 1b <i>6 days</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Carroll County General</i>						d. STREET ADDRESS <i>7 John Street</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>Ernest</i> Last <i>Ellenberg</i>						4. DATE OF DEATH Month <i>June</i> Day <i>30</i> Year <i>1966</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6/24/66</i>		9. AGE (In years last birthday) <i>6</i> yrs.		IF UNDER 1 YEAR Months <i>6</i> Days <i>6</i> Hours <i>1</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Carroll County</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles Ellenberger</i>						14. MOTHER'S MAIDEN NAME <i>Sandra Ridgely</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Sandra Ellenberger</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity Birth wt 2 1/4"</i> <i>7615</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Placenta Previa</i>										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <i>19</i> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <i>6-27</i> , 19 <i>66</i> , to <i>6-30</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>6-29</i> , 19 <i>66</i> , and that death occurred at <i>1:42</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Karl M. Green</i>						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>6/30/66</i>			
22c. PHYSICIAN'S NAME (Type) <i>Karl M. Green MD</i>						22d. ADDRESS <i>181 Fairfield Westminster</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>7/1/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Winters Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Burial Westminster, Md.</i>			
24. FUNERAL DIRECTOR <i>J. S. Myers, Jr., Westminster Md.</i>						24a. REC'D BY REGISTRAR <i>J. Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			
DATE <i>JUL 5 1966</i>											

6-197636

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June 20 66

Charles Sumner

Reply

Received 7/1/66 Boston County
J. S. Rogers, Jr., Westchester, Mass.

Received 7/1/66 Boston County
J. S. Rogers, Jr., Westchester, Mass.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08270

CERTIFICATE OF DEATH

08258

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Lakesville</u>		c. LENGTH OF STAY IN 1b <u>9 mo 15 da</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>1012 Bonaparte Avenue #18</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Daniel James Engelbach</u> First Middle Last		4. DATE OF DEATH <u>June 5</u> 19 <u>66</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>12/24/81</u> 9. AGE (In years last birthday) <u>84</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman - retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Jacob Engelbach</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>none</u>		14. MOTHER'S MAIDEN NAME <u>Mary Sheehon</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>William Engelbach, son, above</u> Address <u>Lakesville Springfield Hospital Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. associated with cerebral arteriosclerosis with</u>			INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>removal of cancer</u>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (his hospital) attended the deceased from <u>8/21</u> , 19 <u>65</u> , to <u>6/5</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>6/5</u> , 19 <u>66</u> , and that death occurred at <u>10:15 AM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Mutshenp</u>		22b. DATE SIGNED <u>6/5/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Alberto D. ARENCO, M.D.</u>		22d. ADDRESS <u>Springfield State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/8/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> ADDRESS <u>3331 Brehms Lane #13</u>		25a. REC'D BY REGISTRAR <u>JUN 7 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
08271					08259					
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Carroll					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bloom Road					d. STREET ADDRESS Bloom Road					
3. NAME OF DECEASED (Type or print) First Oliver Middle R. Last Fair Sr.					4. DATE OF DEATH Month June Day 7 Year 19 66					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 11, 1884		9. AGE (In years last birthday) 81 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired from Congoleum-Nairn Inc.				10b. KIND OF BUSINESS OR INDUSTRY Frederick Co. Md.		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John F. Fair					14. MOTHER'S MAIDEN NAME Elizabeth (Unknown)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. 216-07-3848A		17. INFORMANT Mr. John F. Fair Address Baltimore, Md. 21224			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Insufficiency DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 10 min. 3 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. none 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 9-12-61 , 19____, to 6-7-66 , 19____, that (I) (we) last saw the deceased alive on May 19 , 19 66 , and that death occurred at 2 P M , from the causes and on the date stated above.										
22a. SIGNATURE D. D. Caples					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-8-66			
22c. PHYSICIAN'S NAME (Type) D. D. Caples, M. D.					22d. ADDRESS 6 Hanover Rd., Reisterstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 6/10/66		23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Garden			23d. LOCATION (City, town or county) (State) Finksburg, Md.		
24. FUNERAL DIRECTOR J. F. Eline & Sons					ADDRESS Reisterstown, Md.		25a. REC'D BY REGISTRAR J. Charles Judge		25b. REGISTRAR'S SIGNATURE J. Charles Judge	
DATE JUN 10 1966										

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08272

CERTIFICATE OF DEATH

08260

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - New Windsor</u>		c. LENGTH OF STAY IN TB <u>16 Years</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - New Windsor</u>		d. STREET ADDRESS <u>Route 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>O.</u> Last <u>Farver</u>		4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 16, 1887</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Farver</u>		14. MOTHER'S MAIDEN NAME <u>Jane Young</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-07-9793</u>	
17. INFORMANT <u>Mrs. Martha S. Farver</u>		Address <u>Sykesville, Md. Route 1</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V.D.</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Insufficiency</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1957, 19</u> to <u>6/16/66</u> , that (I) <u>was</u> last saw the deceased alive on <u>5/29/66</u> 19 <u> </u> , and that death occurred at <u>6:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>M. E. Robertson</u>		22b. DATE SIGNED <u>6/16/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. E. Robertson</u>		22d. ADDRESS <u>New Windsor, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/19/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bethany Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Carroll Co., Md.</u>
24. FUNERAL DIRECTOR <u>C. M. Waltz</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		DATE <u>JUN 20 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

00300

CERTIFICATE OF DEATH

00300

THIS CERTIFICATE IS VALID ONLY WHEN
SIGNED BY THE REGISTRAR OF DEATHS
AND THE MEDICAL OFFICER OF HEALTH
AND THE CORONER OR JURY IN THE
CASE OF A SUICIDE OR ACCIDENTAL
DEATH.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08273

CERTIFICATE OF DEATH

08261

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. City & Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>3 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital.</u>		d. STREET ADDRESS <u>822 N Carrollton Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HESTER</u> Middle <u>RYAN</u> Last <u>FLOYD.</u>		4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown.</u>
9. AGE (In years last birthday) <u>74 1/2</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Ryan</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Harris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-01-3509</u>	
17. INFORMANT <u>Hospital records.</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Decubitus ulcers - Toxemia</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> years DUE TO (c) <u>Generalized arterio-sclerosis.</u> years.		INTERVAL BETWEEN ONSET AND DEATH <u>days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>COS. associated with cerebral arterio-sclerosis.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if) (this hospital) attended the deceased from <u>7-27</u> , 19 <u>63</u> , to <u>6-25</u> , 19 <u>66</u> , that (if) (we) last saw the deceased alive on <u>6-25</u> , 19 <u>66</u> , and that death occurred at <u>2:50</u> p.m., from causes and on the date stated above.			
22a. SIGNATURE <u>Suha Ozgun.</u>		22b. DATE SIGNED <u>6-25-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>SUHA OZGUN</u>		22d. ADDRESS <u>Springfield State Hospital.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-29-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Balto Md</u>	
24. FUNERAL DIRECTOR <u>Francis A. Hemsley</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>578 W Biddle St.</u>		DATE <u>JUN 29 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10880

STATE OF TEXAS

10880

NOTICE TO THE PUBLIC
The undersigned, JAMES H. HARRIS, of the County of Tarrant, State of Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the County of Tarrant, State of Texas, and that the same is a true and correct copy of the original as the same appears in the records of the County of Tarrant, State of Texas.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

VR A15 (4)
20M 1/65

08274		MARYLAND STATE DEPARTMENT OF HEALTH	
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
Item 2 Film G378 6/20/66		08262	
mh		Item 9 Film G377 6/16/66	
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminister</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminister, Md.</u>	
c. LENGTH OF STAY IN ID <u>8 months</u>		d. STREET ADDRESS <u>Route #1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Meadow View Nursing Home, Westminister, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Greenwalt</u> Last <u>French</u>		4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>June 17, 1888</u>	
9. AGE (In years last birthday) <u>78 7/22 yrs.</u>		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>22</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Randallstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph F. Greenwalt</u>		14. MOTHER'S MAIDEN NAME <u>Mary Aholt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Mrs. Maureen Lingg, Rt. 1, Dover, Pa.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Transition</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dysphagia</u> (c) <u>Cerebro-vascular accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u> <u>6 wks</u> <u>6 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of uterus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jun 3</u> , 19 <u>65</u> , to <u>June 10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>June 9</u> 19 <u>66</u> , and that death occurred at <u>6:11</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Julius Chopko</u>		22b. DATE SIGNED <u>6/10/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Julius Chopko</u>		22d. ADDRESS <u>854 W. Greent Westminister Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 13, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Pikesville 8, Md.</u>	
24. FUNERAL DIRECTOR <u>Frank H. Newell, Pikesville 8, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 14 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08275

CERTIFICATE OF DEATH

08263

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2yrs. 11mos. 17dys. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 2910 Woodland Ave.	
3. NAME OF DECEASED (Type or print) First JACOB Middle AARON Last GEORGE		4. DATE OF DEATH Month JUNE Day 30 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-1890
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor (ret.)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Paul George		14. MOTHER'S MAIDEN NAME Anna Margaret (last name unk.)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-26-6144	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure due to coronary artery insufficiency DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyelonephritis, right kidney DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) CBS assoc. with circulatory disturbance other than cerebral arteriosclerosis, with psychotic reaction			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-13-63 , 19 63 , to 6-30-66 , 19 66 , that (I) (we) last saw the deceased alive on 6-30-66 , 19 66 , and that death occurred at 6:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Octavio A. Ruiz		22b. DATE SIGNED 7-1-66	
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF July 5, 1966	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City or Town) (County) (State) Sykesville, Balto Co., Md.	
24. FUNERAL DIRECTOR Loring Byers, 8728 Liberty Rd, Randallstown, Md.		25a. REC'D BY REGISTRAR JUL 5 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08276

CERTIFICATE OF DEATH

08264

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN 1b 1mos. 17 dys.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 3448 Reisterstown Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MOLLIE MCHUMMEL GOODMAN				4. DATE OF DEATH Month Day Year June 6 19 66			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/18/89	9. AGE (In years lost birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (County & State, or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A. Naturalized.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-20-2736		17. INFORMANT MR. MILTON B. EDELSON Address 1206 FIDELITY BUILDING #1			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia, due to proteus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypertensive arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							INTERVAL BETWEEN ONSET AND DEATH days years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-19-66 , 19__, to 6-6-66 , 19__, that (I) (we) last saw the deceased alive on 6-6-66 , 19__, and that death occurred at 10:45 A.M. from causes and on the date stated above.							
22a. SIGNATURE Agustin del Campo M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 6-6-66	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JUNE 8, 1966		23c. NAME OF CEMETERY OR CREMATORY OHEB SHALOM		23d. LOCATION (City or Town) (County) (State) O'DONNELL STREET BALTO., MD.	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN				25a. REC'D BY REGISTRAR JUN 9 1966		25b. REGISTRAR'S SIGNATURE J Charles J...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
08277 Item 1d Film G377 6/10/66 mh 08265													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <i>Carroll</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i> c. LENGTH OF STAY IN 1b <i>1 day</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>RFD 1</i>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster RFD 306-1</i> d. STREET ADDRESS <i>(Rural)</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Todd</i> Middle <i>Eric</i> Last <i>Greenwood</i>						4. DATE OF DEATH Month <i>June</i> Day <i>4</i> Year <i>1966</i>							
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8/25/64</i>		9. AGE (In years last birthday) <i>1 10/12 yrs.</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <i>Honover, Pa</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Edward Greenwood</i>						14. MOTHER'S MAIDEN NAME <i>Phyllis McDonald</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Mrs Edward Greenwood 3, Md. Westminster</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bilateral Hemorrhagic pneumonia</i> 493X DUE TO (b) <i>36 hrs</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>11/9/64</i> , 19 <i>64</i> , to <i>6/4</i> , 19 <i>66</i> , that (I/we) last saw the deceased alive on <i>6/3</i> , 19 <i>66</i> , and that death occurred at <i>1:45</i> M, from the causes and on the date stated above.													
22a. SIGNATURE <i>W. H. Foward</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>6/4/66</i>					
22c. PHYSICIAN'S NAME (Type) <i>W. H. Foward, M.D.</i>						22d. ADDRESS <i>Manchester, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6/7/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Evergreen Mem. Gardens</i>				23d. LOCATION (City, town or county) (State) <i>Finksburg, Md.</i>					
24. FUNERAL DIRECTOR <i>Tipton-Eline</i>						ADDRESS <i>Hampstead, Md.</i>		25a. REC'D BY REGISTRAR <i>JUN 8 1966</i>		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>			

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Amelia Hernandez

Amelia Hernandez
June 2, 1966
Hawthorne

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08278

CERTIFICATE OF DEATH

08267

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 32 Marvin Ave				d. STREET ADDRESS 32 Marvin Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Amelia Louise Henritz				4. DATE OF DEATH Month June Day 26 Year 1966			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 20, 1896		9. AGE (In years lost birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Randallstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Phillip Spealman				14. MOTHER'S MAIDEN NAME Helena Frank			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT 32 Marvin Ave. Sykesville Mr. Harry N. Henritz Rte. 4 Box 213			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DEHYDRATION & STARVATION DUE TO (b) METASTATIC CARCINOMATOSIS DUE TO (c) CARCINOMA HEAD PANCREAS							INTERVAL BETWEEN ONSET AND DEATH 2 wks 6 Mo 2 YRS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JUNE 1964 , to 6-26 , 19 66 that (I) (we) last saw the deceased alive on 6-25 , 19 66 , and that death occurred at 12:30 AM , from causes and on the date stated above.							
22a. SIGNATURE R.V. Houck Jr.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-27-66	
22c. PHYSICIAN'S NAME (Type) Dr. R.V. Houck Jr.				22d. ADDRESS SYKESVILLE, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/28/66		23c. NAME OF CEMETERY OR CREMATORY Mt. Olive		23d. LOCATION (City or Town) (County) (State) Randallstown Balto. Md	
24. FUNERAL DIRECTOR Living Byers 8728 Liberty Rd Randallstown				25a. REC'D BY REGISTRAR DATE JUN 30 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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08279
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08268

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville - Rural		c. LENGTH OF STAY IN 1b 66 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Henry First A. Middle Hentzman Last		4. DATE OF DEATH June 8, 19 66 Month June Day 8 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 30, 1896
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 6 Days 1	11. IF UNDER 24 HRS. Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Baltimore City, Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME August Hentzman		14. MOTHER'S MAIDEN NAME Katharina Kohler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-36-8126	
17. INFORMANT Mrs. Mildred L. Hentzman Address Sykesville, Md. Route 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Unknown.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/8/66 , 19 66 , to 6/8 , 19 66 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 4:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE William R O'Rourke M.D.		22b. DATE SIGNED 6/8/66	
22c. PHYSICIAN'S NAME (Type) Dr. William R. O'Rourke		22d. ADDRESS Westminster, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/11/1966	
23c. NAME OF CEMETERY OR CREMATORY Messiah Lutheran Cemetery		23d. LOCATION (City, town, or county) (State) Carroll Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz		25a. REC'D BY REGISTRAR JUN 10 1966	
ADDRESS B ox 241 Sykesville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

85258

CERTIFICATE OF DEATH

85258

MANITOWOC COUNTY, WISCONSIN
OFFICE OF THE REGISTRAR OF DEATHS

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

TIME

PLACE

Cause of Death

Place of Birth

Place of Death

Signature of Registrar

Signature of Physician

Signature of Coroner

Signature of Burial Officer

Signature of Witness

Signature of Minister

Signature of Undertaker

Signature of Funeral Home

Signature of Cemetery

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

CHIEF CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
08280					08269						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <i>Carroll</i> <i>Woodbine</i> MARYLAND					a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodbine</i>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodbine</i>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS <i>Rt 1, Davis Road</i>						
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH						
First Middle Last <i>Katherine Margaritha Herche</i>					Month Day Year <i>June 2 1966</i>						
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 2, 1892</i>		9. AGE (In years last birthday) <i>74</i> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		IF UNDER 1 YEAR Months Days Hours Min.			
13. FATHER'S NAME <i>Nicholas Schlicker</i>					14. MOTHER'S MAIDEN NAME <i>Christina Schwamm</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>					16. SOCIAL SECURITY NO.						
17. INFORMANT <i>John R. Herche, Rt. 1, Davis Road, Mt. Olive Woodbine, Md.</i>					Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Recurrent Cerebral Thrombosis</i> <i>332x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <i>ARTERIO SCLEROSIS - GENERALIZED</i> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>DIABETES MELLITUS, ANGINA PECTORIS 8 YRS. HYPERTENSION</i>										INTERVAL BETWEEN ONSET AND DEATH <i>Two minutes</i> <i>10 YRS</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>1955</i> , 19 <i>55</i> , to <i>JUNE 2</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>6/2</i> 19 <i>66</i> , and that death occurred at <i>6:4</i> AM, from the causes and on the date stated above.											
22a. SIGNATURE <i>G. McGadors MD</i>					22b. DATE SIGNED						
22c. PHYSICIAN'S NAME (Type) <i>G. McGadors MD</i>					22d. ADDRESS <i>810 Bell House Ave. Frederick, MD</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>June 6, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore, Maryland</i>					
24. FUNERAL DIRECTOR <i>G. Truman Schwab, 3512 Frederick Ave. Baltimore Maryland 21229</i>					25a. REC'D BY REGISTRAR <i>JUN 7 1966</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>				

10860

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10860

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT. **M**

08281

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08270

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CARROLL COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gist				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Longview Farm				d. STREET ADDRESS 423 Stratford Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MICHAEL Middle CHARLES Last HIPSLEY				4. DATE OF DEATH Month June Day 12 Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1-14-47		9. AGE (In years last birthday) 19 yrs.	IF UNDER 1 YEAR Months 24 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Milton A. Hipsley, Sr.				14. MOTHER'S MAIDEN NAME Helene E. Skabisky			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Milton A. Hipsley, Sr. Address -423 Stratford			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 866X IMMEDIATE CAUSE (a) Multiple extremities injuries DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Skydiving - Parachute failed to open.					
20c. TIME OF INJURY Month, Day, Year 5:00 Hour 0 a.m. 6-12 19 66 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Longview Farm		20f. (City or town) (County) (State) Gist Carroll, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Russell S. Fisher M.D. EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) 6-13-66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-15-66		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City or Town) (County) (State) Balto., Md.	
24. FUNERAL DIRECTOR Witzke F.D. - 4101 Edmondson Ave.				25a. REC'D BY REGISTRAR JUN 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

08330

08330

08330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08282

08271

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> 06-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>44 RIDGE ROAD</u>				d. STREET ADDRESS <u>44 RIDGE ROAD</u>			
3. NAME OF DECEASED (Type or print) <u>JOHN W JANNEY</u>				4. DATE OF DEATH <u>JUNE 13 1966</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 10, 1894</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FEDERAL EMPLOYEE AND SALESMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CEREDO, W. Va.</u>			
13. FATHER'S NAME <u>WILLIAM D. JANNEY</u>				14. MOTHER'S MAIDEN NAME <u>M. CLARISSA ROWE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>214-01-6588A</u>		17. INFORMANT <u>MRS JOHN W. JANNEY</u>		Address <u>SAME ADDRESS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY THROMBOSIS</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO (c) <u>1 WEEK</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 14, 1966</u> to <u>JUNE 14, 1966</u> , that (I) (we) last saw the deceased alive on <u>JUNE 13, 1966</u> , and that death occurred at <u>6:50 AM</u> , from the causes and on the date stated above.							22b. DATE SIGNED <u>6-13-66</u>
22a. SIGNATURE <u>Daniel I. Welliver</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. PHYSICIAN'S NAME (Type) <u>DANIEL I. WELLIVER</u>	
22d. ADDRESS <u>19 RIDGE ROAD WESTMINSTER MARYLAND</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>BURIAL</u>		<u>6/16/66</u>		<u>DRUID RIDGE CEMETERY</u>		<u>PIKESVILLE, MD.</u>	
24. FUNERAL DIRECTOR <u>J. E. Myers, Jr., Westminster, Md.</u>				25a. REC'D BY REGISTRAR <u>JUN 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

008371

008382

WILLIAM D. JARNEY
FEDERAL EMPLOYEE AND JACOBSON, GEORGE, W. W.
JULY 10 1944 71
M. CLARKSON ROWE
YET WORLD WARR 214-01-2284 MR. JOHN W. JARNEY, MEXICO

DANIEL I. WELLIVER
JUNE 13 1944
BURIAL 6/15/44 DUND RIVER CEMETERY, PIERCEVILLE, MD.
JUN 15 1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08283

CERTIFICATE OF DEATH

08272

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN lb 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Co. General Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GERTRUDE KINDER		4. DATE OF DEATH Month 6 Day 24 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/27/1890
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Sigmund		14. MOTHER'S MAIDEN NAME Lina Machinsky	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 218-18-0948	
17. INFORMANT Mr. Ernest Kinder, Chester, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 245X Necrotizing vasculitis DUE TO (b) _____ DUE TO (c) Penicillin allergy			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/21 , 19 66 to 6/24 , 19 66 , that (I) (we) last saw the deceased alive on 6/24 19 66 , and that death occurred at 3:05 M, from causes on and on the date stated above.			
22a. SIGNATURE John S. Harshey		22b. DATE SIGNED 6/24/66	
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.		22d. ADDRESS Anchor St. Westminster, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/27/66	23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery	23d. LOCATION (City or Town) (County) (State) Upperco Balto. Md.
24. FUNERAL DIRECTOR Tipton-Eline Fun. Home, Hampstead, Md.		25a. REC'D BY REGISTRAR DATE JUN 28 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08284

CERTIFICATE OF DEATH

08273

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminister</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll County Hospital, West</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> 15-2 d. STREET ADDRESS <u>1235 Gladstone Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>PAUL R. KING</u>				4. DATE OF DEATH Month Day Year <u>June 13, 1966</u> 19									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/6/1920</u>		9. AGE (In years last birthday) yrs. <u>46</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>8</u> <u>0</u> <u>0</u> <u>0</u>		IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clarence King</u>						14. MOTHER'S MAIDEN NAME <u>Ruth Trott</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWII</u>				16. SOCIAL SECURITY NO. 		17. INFORMANT Address <u>Nancy H. King - wife- same item #2</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>6/13, 1966</u> , to <u>6/13, 1966</u> , that (I) (we) last saw the deceased alive on <u>6/13, 1966</u> , and that death occurred at <u>6:50</u> M, from causes and on the date stated above.													
22a. SIGNATURE <u>John S. Harshey</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>6/13/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>						22d. ADDRESS <u>8 Archer St. Westminster, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>June 16, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>				23d. LOCATION (City or Town) (County) (State) <u>Arlington Virginia</u>			
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u> ADDRESS <u>1531 Rockville</u> <u>Rockville, Md.</u>						25. REC'D BY REGISTRAR DATE <u>JUN 15 1966</u>				25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, within 72 hours after death.

67524

28530

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08285

08274

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> c. LENGTH OF STAY IN 1b <u>1 Hour</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Carroll County General</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>New Windsor</u> d. STREET ADDRESS <u>Rural - New Windsor</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Philip Keller</u>		4. DATE OF DEATH Month Day Year <u>6 5 1966</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/5/66</u>		9. AGE (In years last birthday) yrs. <u>1</u> <u>12</u>		IF UNDER 1 YEAR Months Days <u>1 12</u>		IF UNDER 24 HRS. Hours Min. <u>1 12</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Carroll County</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>					
13. FATHER'S NAME <u>Philip L. Keller</u>								14. MOTHER'S MAIDEN NAME <u>Emma Pittenger</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Emma Keller</u> Address <u>Rt. 2 Sykesville, Md.</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diaphragmatic Hernia</u> <u>5604</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ (e), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____												INTERVAL BETWEEN ONSET AND DEATH <u>Birth</u>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>				20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>6-5, 1966</u> , to <u>6-6, 1966</u> , that (I) (we) last saw the deceased alive on <u>6-5, 1966</u> , and that death occurred at <u>6:15 P.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Karl M. Green</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/5/66</u>		22c. PHYSICIAN'S NAME (Type) <u>KARL M. GREEN MD</u>						22d. ADDRESS <u>181 Fairfield Ave, Westminster</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>6/7/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wesley Freedom Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Carroll Co., Md.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz</u>						ADDRESS <u>Box 241 Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 9 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

08286

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08275

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Manchester c. LENGTH OF STAY IN 1b 06-1 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Westminster Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Manchester d. STREET ADDRESS Westminster Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PAUL Middle LEROY Last LEESE, Jr.		4. DATE OF DEATH Month 6 Day 9 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1937
9. AGE (In years last birthday) 28 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b. KIND OF BUSINESS OR INDUSTRY Laundry & Cleaners--Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Paul L. Leese, Sr.		14. MOTHER'S MAIDEN NAME Hilda Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-34-0073	
17. INFORMANT Mrs. Fay Leese		Address Manchester, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Base of Skull DUE TO Fracture of Base of Skull (b) Fracture of R. Hemerus DUE TO Fracture of R. Hemerus (c) Motor Vehicle Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2154	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) motorcycle - head on collision with car.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 7 p.m. 6-9 19 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Manchester Carroll Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Maurice C. Portner EXAMINER'S NAME (Type) acting		22. DATE SIGNED 6-9-66 HAMPSTEAD, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/12/66	
23c. NAME OF CEMETERY OR CREMATORY Manchester Cemetery		23d. LOCATION (City, town or county) (State) Manchester Md.	
24. FUNERAL DIRECTOR Tipton-Eline		25a. REC'D BY REGISTRAR JUN 14 1966	
ADDRESS Hampstead, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
08287					08276				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)				
a. COUNTY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			a. STATE		b. COUNTY		
CARROLL		SYKESVILLE			MARYLAND		BALTIMORE		
c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
7 months 22 days		Springfield State Hospital			BALTIMORE		No fixed address		
3. NAME OF DECEASED (Type or print)				First		Middle		Last	
JOHN				NMN		LENNON		DATE OF DEATH	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		1905		61 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
ORDERLY				HOSPITAL		IRELAND		UNK.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
WILLIAM LEONN				NOT KNOWN				16. SOCIAL SECURITY NO.	
UNKNOWN				UNKNOWN				17. INFORMANT	
				Records				Address	
								Springfield State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 158X Terminal Ca DUE TO (b) Ascites Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH One mo. weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-13, 1965, to 6-4, 1966, that (I) (we) last saw the deceased alive on 6-4, 1966, and that death occurred at 7A. M. from the causes and on the date stated above.									
22a. SIGNATURE R. G. Lajonchere MD				M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) R. Lajonchere				22d. ADDRESS Springf. state Hosp.		22b. DATE SIGNED 6-4-66			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		6-11-66		New Cathedral		BALTIMORE, MD.			
24. FUNERAL DIRECTOR Arthur H. Haight				ADDRESS Sykesville, Md.		25a. REC'D BY REGISTRAR JUN 13 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

08238

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Section

Information

Information

JUN 13 1961

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08288

CERTIFICATE OF DEATH

08277

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 24 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 20852 15-2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			d. STREET ADDRESS 6716 Tildenwood Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Adelbert Middle Frank Last ORMSBY			4. DATE OF DEATH Month June Day 25 Year 1966		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7-15-87		9. AGE (In years last birthday) 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman - retired		10b. KIND OF BUSINESS OR INDUSTRY ??	11. BIRTHPLACE (County & State, or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Frank Ormsby - dec.			14. MOTHER'S MAIDEN NAME Jennie Misick - dec.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes Reserves-52 yrs.		16. SOCIAL SECURITY NO. 360-10-9837	17. INFORMANT Address Springfield State Hosp., Sykesville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary abscess 521X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease. Old subdural hematoma.					INTERVAL BETWEEN ONSET AND DEATH weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 6-1-66 , 19__, to 6-25-66 , 19__, that (I) (we) last saw the deceased alive on 6-25-66 19__, and that death occurred at 7 P.M. from causes and on the date stated above.					
22a. SIGNATURE <i>[Signature]</i> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 6-26-66		
22c. PHYSICIAN'S NAME (Type) Naci N. Buyukinsal, MD.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 28, 1966	23c. NAME OF CEMETERY OR CREMATORY Parklawn	23d. LOCATION (City or Town) (County) (State) Rockville Maryland		
24. FUNERAL DIRECTOR ADDRESS Robert A. Pumphrey Bethesda, Maryland			25a. REC'D BY REGISTRAR DATE JUN 29 1966	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08333

CERTIFICATE OF BIRTH

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Birthplace of father

Birthplace of mother

Birthplace

Birthplace

June 28, 1906

Birthplace

Robert A. Humphrey, Bethesda, Maryland

June 28, 1906

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
08289					CERTIFICATE OF DEATH					08278									
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>			c. LENGTH OF STAY IN 1b <u>1 Yr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead - Route 2 06-1</u>														
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Long View Nursing Home, Inc.</u>					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>Elizabeth</u> Last <u>Patterson</u>					4. DATE OF DEATH Month <u>6</u> Day <u>6</u> Year <u>1966</u>														
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-19-1869</u>		9. AGE (In years last birthday) <u>96 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll - Manchester, Md.</u>					12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Charles Hunt</u>					14. MOTHER'S MAIDEN NAME <u>Sophia Weaner</u>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Virgie Baubitz</u>		Address <u>Hampstead, Md. Route 2</u>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>					20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>July 15</u> , 19 <u>66</u> , to <u>June 6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>June 5</u> , 19 <u>66</u> , and that death occurred at <u>4:30</u> A.M. from the causes and on the date stated above.																			
22a. SIGNATURE <u>Joseph E. Bush</u>					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/6/66</u>												
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>					22d. ADDRESS <u>Hampstead Maryland</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>6/8/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beckleysville</u>			23d. LOCATION (City, town or county) (State) <u>Balto. Co Md.</u>									
24. FUNERAL DIRECTOR <u>Tipton-Eline</u>					ADDRESS <u>Hampstead, Md.</u>					25a. REC'D BY REGISTRAR <u>JUN 8 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08290

08279

1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 4yrs. 11mo. 27da. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2702 Goodwood Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARIE First (NMN) Middle RAMMES Last		4. DATE OF DEATH JUNE 27 19 66 Month Day Year		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8-29-04 9. AGE (in years last birthday) 61 yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Department Store Clerk		10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Gernhardt				14. MOTHER'S MAIDEN NAME Rose			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-14-7007		17. INFORMANT Records Address Sykesville Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition and dehydration 305 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pre-senile brain disease (c) Fecal impaction. Multiple decubitus.	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with presenile brain disease with psychotic reaction.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-30- , 19 61 to 6-27- , 19 66 that (I) (we) last saw the deceased alive on 6-27- , 19 66 , and that death occurred at 12:10 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Ernest Beiser, M.D.				22b. DATE SIGNED June 27, 1966		22c. PHYSICIAN'S NAME (Type) Ernest Beiser, M.D.	
22d. ADDRESS Springfield State Hospital Sykesville, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
23b. DATE THEREOF 6-30-66		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland		24. FUNERAL DIRECTOR Robert C. Altenburg Funeral Home Inc.	
25a. REC'D BY REGISTRAR JUN 30 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					

MEDICAL CERTIFICATION

088379

DEPARTMENT OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08291

08280

1. PLACE OF DEATH e. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Mt. Airy</u> c. LENGTH OF STAY IN 1b <u>11 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Md. Route 144</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Mount Airy</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Charles Albert Randle</u> First Middle Last				4. DATE OF DEATH <u>June 11 1966</u> Month Day Year					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 18, 1890</u>		9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Motor Express</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland Balto. Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore Randle</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Griffith</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>215-09-9342</u>		17. INFORMANT <u>Mrs. Charles A. Randle, Mt. Airy, Md</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>4301</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Cardiovascular Disease</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>April 1963</u> to <u>June 1966</u> , that (I) (we) last saw the deceased alive on <u>June 4 1966</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>W.B. Culwell</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>June 11, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>				22d. ADDRESS <u>Mount Airy, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-14-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>E.M. Watz</u> ADDRESS <u>Box 241, Sykesville, Md</u>				25a. REC'D BY REGISTRAR <u>JUN 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08292

08281

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland				b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 1mo. 1 dy.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monrovia 15-2			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital								d. STREET ADDRESS Unk			
3. NAME OF DECEASED (Type or print) DOROTHY MAY RANDOLPH				First Middle Last Randolph				4. DATE OF DEATH June 17 1966			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-13-29		9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Howard Duvall						14. MOTHER'S MAIDEN NAME Edith Taylor					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 220-26-0498		17. INFORMANT Records, Springfield State Hospital					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 465 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)										INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic Reaction, Chronic Undifferentiated type										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Maurice C. Porterfield				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED 6-17-66			
EXAMINER'S NAME (Type) Maurice D. Porterfield, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) HAMPSTEAD, CARROLL			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
Burial		6/22/66		John Wesley Cemetery		Clarksburg, Md.					
24. FUNERAL DIRECTOR George R. Snowden				ADDRESS Rockville				25a. REC'D BY REGISTRAR JUN 23 1966			
								25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

088841

088841

JUN 2 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

08293		08282	
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City Po</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN lb <u>8 yrs.</u>		30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>3904 Southern Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>None</u> Last <u>Ray</u>		4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-7-95</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>Lithuania</u>	
13. FATHER'S NAME <u>Anton</u>		14. MOTHER'S MAIDEN NAME <u>? Unknown.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-54-7420</u>	
17. INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA - Hemorrhage.</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic cardiovascular disease</u> DUE TO (c) <u>generalized arterio-sclerosis.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>years</u> <u>years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CBS associated with brain trauma, gross force without qualifying phrase</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-18-1958</u> , to <u>6-18-1966</u> , that (I) (we) last saw the deceased alive on <u>6-18-1966</u> , and that death occurred at <u>6:00 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Suha Ozgun.</u>		22b. DATE SIGNED <u>6-18-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>SUHA OZGUN.</u>		22d. ADDRESS <u>Springfield State Hosp. Sykesville Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-25-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO. Md.</u>	
24. FUNERAL DIRECTOR <u>Harry W. Knight</u>		25a. REC'D BY REGISTRAR <u>Sykesville, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUN 27 1966</u>	

MEDICAL CERTIFICATION

48888

CERTIFICATE OF DEATH

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Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Medical Officer	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08294

08283

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b Hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Paul Middle W. Last Rice-Sr.		4. DATE OF DEATH Month June Day 1- Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11-1911
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months 54 Days 1 Hours 1 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		12. KIND OF BUSINESS OR INDUSTRY R. Road Brakeman	
13. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME Wm. C. Rice- living		16. MOTHER'S MAIDEN NAME Ada Rebecca Ausherman- deceased	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		18. SOCIAL SECURITY NO. 214-10-2222	
19. INFORMANT Mrs. Myrtle E. Rice-		Address Dulaney Ave. Frederick-Md.	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY THROMBOSIS DUE TO SUDDEN DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO 5 1/2 (c)		INTERVAL BETWEEN ONSET AND DEATH 5 1/2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1 , 19 62 , to 1 , 19 66 that (we) last saw the deceased alive on 5/31 19 66 , and that death occurred at 3:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Richard C Reynolds, M.D.		22b. DATE SIGNED June 2-1966	
22c. PHYSICIAN'S NAME (Type) Dr. Richard C. Reynolds		22d. ADDRESS 804 Toll House Ave.-Frederick-Md. 21701	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 4-1966	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701	
24. FUNERAL DIRECTOR M.R. Etchison & Son		25. REGISTRAR'S SIGNATURE Elwood Whitmore	
25a. ADDRESS Frederick, Md. 21701		25b. REGISTRAR'S SIGNATURE J. Charles Judge	
25c. REC'D BY REGISTRAR JUN 6 1966		25d. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR AIS (4)
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Item 13 Film G378-- 7/1/66 mk

08284

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hampstead</u>		c. LENGTH OF STAY IN lb <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hocksville Rd</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ethel</u> First <u>Lozaine</u> Middle <u>Richards</u> Last		4. DATE OF DEATH <u>June</u> 23 19 <u>66</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 3, 1897</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Carroll County Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Nora Virginia Brunnel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-36-8784</u>	
17. INFORMANT <u>Frank A Richards, Hampstead Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Hypertensive Cardiovascular Disease</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>9/19/1965</u> , to <u>June 23, 1966</u> , that (I) (we) last saw the deceased alive on <u>June 10, 1966</u> , and that death occurred at <u>7:45</u> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Bush</u> M.D.		22b. DATE SIGNED <u>June 23, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush M.D.</u>		22d. ADDRESS <u>Hampstead Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/26/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Wesley Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Carroll Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton-Eline</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Hampstead, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08296

08285

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville		c. LENGTH OF STAY IN 1b Oyr. Omo. 6d.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital						d. STREET ADDRESS 5318 Grindon Avenue			
3. NAME OF DECEASED (Type or print) Laurence (NMN) Richmond		4. DATE OF DEATH Month 6 Day 9 Year 19 66		5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 7-22-95		9. AGE (In years last birthday) yrs. 70		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) xxxxxx Retired Salesman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Henry Holland Richmond		14. MOTHER'S MAIDEN NAME Nancy Wright		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes, Navy 19-18-1919		16. SOCIAL SECURITY NO. 216-07-8941	
17. INFORMANT Hospital Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS UNDERLYING: IMMEDIATE CAUSE (a) Cardiac failure due to renal insufficiency DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) Chronic brain syndrome associated with cerebral arterio-sclerosis, with psychotic reaction.		INTERVAL BETWEEN ONSET AND DEATH days years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---		20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. ---		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	
20f. (City or town) (County) (State) ---		21. I certify that (this hospital) attended the deceased from 6-3 , 1966, to 6-9 , 1966, that (I) (we) last saw the deceased alive on 6-9 , 1966, and that death occurred at 10:50 P.M. , from causes and on the date stated above.		22a. SIGNATURE <i>Heinz H. Klaatsch</i>		22b. DATE SIGNED 6-10-66		22c. PHYSICIAN'S NAME (Type) Heinz H. Klaatsch, M.D.	
22d. ADDRESS Springfield State Hospital		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/13/66.		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR JUN 14 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08297

CERTIFICATE OF DEATH

08286

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville			c. LENGTH OF STAY IN 1b 4mo. 13days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City 13-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 76 Church Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Hunt Last Rogers				4. DATE OF DEATH Month 6 Day 8 Year 1966				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/9/92		
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Brattan				14. MOTHER'S MAIDEN NAME Elizabeth Hunt				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. unknown		17. INFORMANT Springfield Hospital records, Sykesville			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Branchopneumonia DUE TO (b) Arterio-sclerotic cardiovascular disease DUE TO (c) years.							INTERVAL BETWEEN ONSET AND DEATH days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with alcohol intoxication without qualifying phrase.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (if) (this hospital) attended the deceased from 1-25- , 19 66 , to 6-8 , 19 66 , that it (we) last saw the deceased alive on 6-8 , 19 66 , and that death occurred at 1:00 P.M. , from causes and on the date stated above.								
22a. SIGNATURE Suha Ozgun				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 6/8/66		
22c. PHYSICIAN'S NAME (Type) Suha Ozgun, M. D.				22d. ADDRESS Springfield State Hospital Sykesville, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 6/10/66		23c. NAME OF CEMETERY OR CREMATORY St Johns		23d. LOCATION (City or Town) (County) (State) Ellicott City, Md.		
24. PLACE OF INTERMENT St Johns, Ellicott City, Md.				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08298

08287

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN b 1 yr. 1 mo. 7 dys. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2665 Oswego Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last RONALD MYRON ROSEN				4. DATE OF DEATH Month Day Year June 7 19 66			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-6-33	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) Maryland, BALTIMORE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mitchell Rosen				14. MOTHER'S MAIDEN NAME Barbara Bauer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-32-5588		17. INFORMANT Mitchell Rosen, 3624 FORDS LANE #15			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pneumonitis 323X DUE TO Conditions, if any, which gave rise to immediate cause (b) Drug Addictions (Overdose) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 15 yrs.						INTERVAL BETWEEN ONSET AND DEATH 3 days	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Maurice C. Porterfield EXAMINER'S NAME (Type) Maurice C. Porterfield, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6-7-66			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 10, 1966		22c. NAME OF CEMETERY OR CREMATORY OHEL YAKOV CONG		22d. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
23. FUNERAL DIRECTOR Edwinson & Bros ADDRESS 6010 REISTERSTOWN ROAD				24a. REC'D BY REGISTRAR JUN 14 1966 24b. REGISTRAR'S SIGNATURE Charles Judge			

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ALCOHOLIC BEVERAGES - DISTILLERS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
08299					08288				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <u>Carroll</u>					a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> 06-1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>25 East George St.</u>					d. STREET ADDRESS <u>25 East George St.</u>				
3. NAME OF DECEASED (Type or print) <u>ANNA MARIE ROTHENBERGER</u>					4. DATE OF DEATH <u>JUNE 16 1966</u>				
5. SEX <u>female</u>					6. COLOR OR RACE <u>white</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>Oct. 1, 1913</u>				
9. AGE (in years last birthday) <u>52</u> yrs.					10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
11. BIRTHPLACE (County & State, or foreign country) <u>Westminster, Md.</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>David William Rothenberger</u>					14. MOTHER'S MAIDEN NAME <u>Martha Helena Dell</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u>216-14-6422</u>				
17. INFORMANT <u>Charles W. Rothenberger</u>					Address <u>same address</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>170X</u> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastatic carcinoma of breast</u> (c) <u>1 year</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 1, 1965</u> , to <u>June 14, 1966</u> , that (I) (we) last saw the deceased alive on <u>June 14, 1966</u> , and that death occurred at <u>1:30</u> A.M. from the causes and on the date stated above.									
22a. SIGNATURE <u>C. L. Billingslea</u>					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) <u>C. L. Billingslea</u>					22d. ADDRESS <u>Westminster, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>6/20/66</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Catholic Cemetery</u>					23d. LOCATION (City, town or county) (State) <u>Westminster, Md.</u>				
24. FUNERAL DIRECTOR <u>J. E. Myers, Jr.</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>				
25b. REGISTRAR'S SIGNATURE					DATE <u>JUN 20 1966</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or entombment, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08300

08289

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. LENGTH OF STAY IN 1b 14 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 3102 Rueckert Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Regina Last Russell		4. DATE OF DEATH Month 6 Day 7 Year 1966	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/26/20
9. AGE (In years last birthday) yrs. 46		IF UNDER 1 YEAR Months 6 Days 7 Hours 19 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office clerk		10b. KIND OF BUSINESS OR INDUSTRY Credit Co.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Sinclair		14. MOTHER'S MAIDEN NAME Mary Sturgeon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 217-03-5726	
17. INFORMANT unknown		Address Springfield Hospital records, Sykesville	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic infarction of the right hemisphere of the brain, organism unknown DUE TO 3403 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Acute meningitis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Days or weeks Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome with circulatory disorder (CVA) with psychotic reaction.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 71 (this hospital) attended the deceased from 5/23/1966 to 6/7/1966 , that 71 (we) last saw the deceased alive on 6/7/1966 , and that death occurred at 8:25 p.m. from causes on and on the date stated above.			
22a. SIGNATURE Luis J. Arribas, M.D. M.D.		22b. DATE SIGNED 6/8/66	
22c. PHYSICIAN'S NAME (Type) Luis J. Arribas, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/13/66.	
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214		25. REC'D BY REGISTRAR DATE JUN 9 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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STATEMENT OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN lb <u>10 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		<u>06-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>469 E. GREEN ST.</u>				d. STREET ADDRESS <u>464 E. GREEN ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ZACHARY NICHOLAS SAMIOS</u>		First Middle Last		4. DATE OF DEATH		Month Day Year <u>JUNE 3 1966</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 20, 1895</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STORE OPERATOR (RETIRED)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NYTHERA GREECE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NICHOLAS SAMIOS</u>				14. MOTHER'S MAIDEN NAME <u>TINA KYPRITON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>205-22-4947</u>		17. INFORMANT <u>ARTHUR N. SAMIOS</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ARTERIO-SCLEROTIC CARDIOVASCULAR DIS</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>10 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 1962</u> to <u>JUNE 1966</u> that (I) (we) last saw the deceased alive on <u>JUNE 3, 1966</u> and that death occurred at <u>9 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Daniel I. Welliver</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-3-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>DANIEL I. WELLIVER</u>				22d. ADDRESS <u>19 RIDGE ROAD WESTMINSTER MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6/6/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN MEM GARDENS</u>		23d. LOCATION (City, town or county) (State) <u>FINKSBURG MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Jones, Jr., Westminster, Md.</u>				ADDRESS <u>Westminster, Md.</u>		25. REC'D BY REGISTRAR <u>JUN 6 1966</u>	
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

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NICHOLAS 2 AMIC2
STAKE OPERATOR (RETIRED) KYTHERA GREECE U-2-0
TINA KYPRITON, WESTMINSTER
202-22-2147200 N. 2 AMIC2

JOURNAL 6/6/86 EVERGREEN MEMORIAL PARK, FINKSBURG, MD
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural -- Sykesville</u>			c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clear Spring, Maryland</u> <u>21-2</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>					d. STREET ADDRESS <u>Route # 1</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Helen</u> First <u>Bessie</u> Middle <u>Seibert</u> Last			4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1966</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 10, 1900</u> <u>66</u> yrs.		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min. <u>66</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Wilson, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Franklin Hull</u>					14. MOTHER'S MAIDEN NAME <u>Margaretta Catherine Coon</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>214-34-0935</u>		17. INFORMANT <u>Springfield Hospital Records, Sykesville</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary congestion</u> <u>305X</u> DUE TO (b) <u>Cardiac Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>CBS associated with alzheimer's disease</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CBS associated with cerebral arteriosclerosis with psychosis</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (this hospital) attended the deceased from <u>June 17</u> , 19 <u>66</u> , to <u>June 27</u> , 19 <u>66</u> , that (he/she) last saw the deceased alive on <u>June 27</u> , 19 <u>66</u> , and that death occurred at <u>8:15 PM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Luis J. Arribas</u>					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) <u>Luis J. Arribas, M.D.</u>					22d. ADDRESS <u>Springfield State Hospital</u> <u>Sykesville, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 30, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>St. Paul, Washington Co., MD</u>			
24. FUNERAL DIRECTOR <u>Donald E. Thompson</u>					25a. REC'D BY REGISTRAR <u>JUL 1 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
Thompson Funeral Home, Clear Spring, Md.									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08308		Item #2b, c & d Film #G378 6/23/66		08291	
1. PLACE OF DEATH a. COUNTY <i>Carroll</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Sikesville</i> c. LENGTH OF STAY IN 1b <i>Golden Age Guest Home</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Sikesville Dundalk</i> d. STREET ADDRESS <i>718 McCabe Ave.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Agnes</i> Middle <i>Seymour</i> Last <i>Seymour</i>		4. DATE OF DEATH Month <i>June</i> Day <i>12</i> Year <i>1966</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>10-27-1895</i>		9. AGE (In years last birthday) <i>70</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>03</i> Days <i>2</i> Hours <i>00</i> Min. <i>00</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>William Whittie</i>		14. MOTHER'S MAIDEN NAME <i>Mary O'Neill</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>William W. Seymour</i> Address <i>718 McCabe Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> <i>350X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Parkinson Disease</i> DUE TO (c) <i>Syr</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 wk</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>9/5/58</i> , 19 <i>58</i> , to <i>June 12, 1966</i> , that (I) (we) last saw the deceased alive on <i>June 12, 1966</i> , and that death occurred at <i>8:00</i> M, from the causes and on the date stated above.					
22a. SIGNATURE <i>H. H. Mastin</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>June 12-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>M H MASTIN</i>		22d. ADDRESS <i>Hestonster Ind.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>6-15-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>	
23d. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i>					
24. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc</i> ADDRESS <i>Baltimore, Md.</i>		25a. REC'D BY REGISTRAR <i>JUN 16 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Sykesville</u>		c. LENGTH OF STAY IN 1b <u>21 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sheridan Phillip Sheffer</u>		4. DATE OF DEATH <u>6 24 19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-4-96</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steelworker</u>		12. BIRTHPLACE (County & State, or foreign country) <u>New York</u>	
13. FATHER'S NAME <u>Clifford Sheffer</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Dykeman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>113-14-0285</u>	
17. INFORMANT <u>Springfield Hospital Records, Sykesville</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. Cerebral Arteriosclerosis & Psychotic Reaction</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from <u>6-3</u> , 19 <u>66</u> , to <u>6-24</u> , 19 <u>66</u> , that he (we) last saw the deceased alive on <u>6-24</u> , 19 <u>66</u> , and that death occurred at <u>6:35 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>M. Arango</u>		22b. DATE SIGNED <u>6/24/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. Arango - M.D.</u>		22d. ADDRESS <u>Springfield State Hospital, Sykesville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/27/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Immanuel Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Manchester Carroll Md.</u>
24. FUNERAL DIRECTOR <u>Tipton-Eline Fun. Home</u>		25a. REC'D BY REGISTRAR <u>Hampstead, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUN 28 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. Name of the person or organization		2. Address	
3. City		4. State	
5. Zip		6. Telephone	
7. Date		8. Signature	
9. Title		10. Organization	
11. Purpose of the visit		12. Other information	
13. Name of the person or organization		14. Address	
15. City		16. State	
17. Zip		18. Telephone	
19. Date		20. Signature	
21. Title		22. Organization	
23. Purpose of the visit		24. Other information	
25. Name of the person or organization		26. Address	
27. City		28. State	
29. Zip		30. Telephone	
31. Date		32. Signature	
33. Title		34. Organization	
35. Purpose of the visit		36. Other information	
37. Name of the person or organization		38. Address	
39. City		40. State	
41. Zip		42. Telephone	
43. Date		44. Signature	
45. Title		46. Organization	
47. Purpose of the visit		48. Other information	
49. Name of the person or organization		50. Address	
51. City		52. State	
53. Zip		54. Telephone	
55. Date		56. Signature	
57. Title		58. Organization	
59. Purpose of the visit		60. Other information	
61. Name of the person or organization		62. Address	
63. City		64. State	
65. Zip		66. Telephone	
67. Date		68. Signature	
69. Title		70. Organization	
71. Purpose of the visit		72. Other information	
73. Name of the person or organization		74. Address	
75. City		76. State	
77. Zip		78. Telephone	
79. Date		80. Signature	
81. Title		82. Organization	
83. Purpose of the visit		84. Other information	
85. Name of the person or organization		86. Address	
87. City		88. State	
89. Zip		90. Telephone	
91. Date		92. Signature	
93. Title		94. Organization	
95. Purpose of the visit		96. Other information	
97. Name of the person or organization		98. Address	
99. City		100. State	
101. Zip		102. Telephone	
103. Date		104. Signature	
105. Title		106. Organization	
107. Purpose of the visit		108. Other information	
109. Name of the person or organization		110. Address	
111. City		112. State	
113. Zip		114. Telephone	
115. Date		116. Signature	
117. Title		118. Organization	
119. Purpose of the visit		120. Other information	
121. Name of the person or organization		122. Address	
123. City		124. State	
125. Zip		126. Telephone	
127. Date		128. Signature	
129. Title		130. Organization	
131. Purpose of the visit		132. Other information	
133. Name of the person or organization		134. Address	
135. City		136. State	
137. Zip		138. Telephone	
139. Date		140. Signature	
141. Title		142. Organization	
143. Purpose of the visit		144. Other information	
145. Name of the person or organization		146. Address	
147. City		148. State	
149. Zip		150. Telephone	
151. Date		152. Signature	
153. Title		154. Organization	
155. Purpose of the visit		156. Other information	
157. Name of the person or organization		158. Address	
159. City		160. State	
161. Zip		162. Telephone	
163. Date		164. Signature	
165. Title		166. Organization	
167. Purpose of the visit		168. Other information	
169. Name of the person or organization		170. Address	
171. City		172. State	
173. Zip		174. Telephone	
175. Date		176. Signature	
177. Title		178. Organization	
179. Purpose of the visit		180. Other information	
181. Name of the person or organization		182. Address	
183. City		184. State	
185. Zip		186. Telephone	
187. Date		188. Signature	
189. Title		190. Organization	
191. Purpose of the visit		192. Other information	
193. Name of the person or organization		194. Address	
195. City		196. State	
197. Zip		198. Telephone	
199. Date		200. Signature	
201. Title		202. Organization	
203. Purpose of the visit		204. Other information	
205. Name of the person or organization		206. Address	
207. City		208. State	
209. Zip		210. Telephone	
211. Date		212. Signature	
213. Title		214. Organization	
215. Purpose of the visit		216. Other information	
217. Name of the person or organization		218. Address	
219. City		220. State	
221. Zip		222. Telephone	
223. Date		224. Signature	
225. Title		226. Organization	
227. Purpose of the visit		228. Other information	
229. Name of the person or organization		230. Address	
231. City		232. State	
233. Zip		234. Telephone	
235. Date		236. Signature	
237. Title		238. Organization	
239. Purpose of the visit		240. Other information	
241. Name of the person or organization		242. Address	
243. City		244. State	
245. Zip		246. Telephone	
247. Date		248. Signature	
249. Title		250. Organization	
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253. Name of the person or organization		254. Address	
255. City		256. State	
257. Zip		258. Telephone	
259. Date		260. Signature	
261. Title		262. Organization	
263. Purpose of the visit		264. Other information	
265. Name of the person or organization		266. Address	
267. City		268. State	
269. Zip		270. Telephone	
271. Date		272. Signature	
273. Title		274. Organization	
275. Purpose of the visit		276. Other information	
277. Name of the person or organization		278. Address	
279. City		280. State	
281. Zip		282. Telephone	
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295. Date		296. Signature	
297. Title		298. Organization	
299. Purpose of the visit		300. Other information	
301. Name of the person or organization		302. Address	
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305. Zip		306. Telephone	
307. Date		308. Signature	
309. Title		310. Organization	
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313. Name of the person or organization		314. Address	
315. City		316. State	
317. Zip		318. Telephone	
319. Date		320. Signature	
321. Title		322. Organization	
323. Purpose of the visit		324. Other information	
325. Name of the person or organization		326. Address	
327. City		328. State	
329. Zip		330. Telephone	
331. Date		332. Signature	
333. Title		334. Organization	
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337. Name of the person or organization		338. Address	
339. City		340. State	
341. Zip		342. Telephone	
343. Date		344. Signature	
345. Title		346. Organization	
347. Purpose of the visit		348. Other information	
349. Name of the person or organization		350. Address	
351. City		352. State	
353. Zip		354. Telephone	
355. Date		356. Signature	
357. Title		358. Organization	
359. Purpose of the visit		360. Other information	
361. Name of the person or organization		362. Address	
363. City		364. State	
365. Zip		366. Telephone	
367. Date		368. Signature	
369. Title		370. Organization	
371. Purpose of the visit		372. Other information	
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375. City		376. State	
377. Zip		378. Telephone	
379. Date		380. Signature	
381. Title		382. Organization	
383. Purpose of the visit		384. Other information	
385. Name of the person or organization		386. Address	
387. City		388. State	
389. Zip		390. Telephone	
391. Date		392. Signature	
393. Title		394. Organization	
395. Purpose of the visit		396. Other information	
397. Name of the person or organization		398. Address	
399. City		400. State	
401. Zip		402. Telephone	
403. Date		404. Signature	
405. Title		406. Organization	
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413. Zip		414. Telephone	
415. Date		416. Signature	
417. Title		418. Organization	
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423. City		424. State	
425. Zip		426. Telephone	
427. Date		428. Signature	
429. Title		430. Organization	
431. Purpose of the visit		432. Other information	
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435. City		436. State	
437. Zip		438. Telephone	
439. Date		440. Signature	
441. Title		442. Organization	
443. Purpose of the visit		444. Other information	
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449. Zip		450. Telephone	
451. Date		452. Signature	
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455. Purpose of the visit		456. Other information	
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459. City		460. State	
461. Zip		462. Telephone	
463. Date		464. Signature	
465. Title		466. Organization	
467. Purpose of the visit		468. Other information	
469. Name of the person or organization		470. Address	
471. City		472. State	
473. Zip		474. Telephone	
475. Date		476. Signature	
477. Title		478. Organization	
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481. Name of the person or organization		482. Address	
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485. Zip		486. Telephone	
487. Date		488. Signature	
489. Title		490. Organization	
491. Purpose of the visit		492. Other information	
493. Name of the person or organization		494. Address	
495. City		496. State	
497. Zip		498. Telephone	
499. Date		500. Signature	
501. Title		502. Organization	
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509. Zip		510. Telephone	
511. Date		512. Signature	
513. Title		514. Organization	
515. Purpose of the visit		516. Other information	
517. Name of the person or organization		518. Address	
519. City		520. State	
521. Zip		522. Telephone	
523. Date		524. Signature	
525. Title		526. Organization	
527. Purpose of the visit		528. Other information	
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533. Zip		534. Telephone	
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537. Title		538. Organization	
539. Purpose of the visit		540. Other information	
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545. Zip		546. Telephone	
547. Date		548. Signature	
549. Title		550. Organization	
551. Purpose of the visit		552. Other information	
553. Name of the person or organization		554. Address	
555. City		556. State	
557. Zip		558. Telephone	
559. Date		560. Signature	
561. Title		562. Organization	
563. Purpose of the visit		564. Other information	
565. Name of the person or organization		566. Address	
567. City		568. State	
569. Zip		570. Telephone	
571. Date		572. Signature	
573. Title		574. Organization	
575. Purpose of the visit		576. Other information	
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579. City		580. State	
581. Zip		582. Telephone	
583. Date		584. Signature	
585. Title		586. Organization	
587. Purpose of the visit		588. Other information	
589. Name of the person or organization		590. Address	
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593. Zip		594. Telephone	
595. Date		596. Signature	
597. Title		598. Organization	
599. Purpose of the visit		600. Other information	
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603. City		604. State	
605. Zip		606. Telephone	
607. Date		608. Signature	
609. Title		610. Organization	
611. Purpose of the visit		612. Other information	
613. Name of the person or organization		614. Address	
615. City		616. State	
617. Zip		618. Telephone	
619. Date		620. Signature	
621. Title		622. Organization	
623. Purpose of the visit		624. Other information	
625. Name of the person or organization		626. Address	
627. City		628. State	
629. Zip		630. Telephone	
631. Date		632. Signature	
633. Title		634. Organization	
635. Purpose of the visit		636. Other information	
637. Name of the person or organization		638. Address	
639. City		640. State	
641. Zip		642. Telephone	
643. Date		644. Signature	
645. Title		646. Organization	
647. Purpose of the visit		648. Other information	
649. Name of the person or organization		650. Address	
651. City		652. State	
653. Zip		654. Telephone	
655. Date		656. Signature	
657. Title		658. Organization	
659. Purpose of the visit		660. Other information	
661. Name of the person or organization		662. Address	
663. City		664. State	
665. Zip		666. Telephone	
667. Date		668. Signature	
669. Title		670. Organization	
671. Purpose of the visit		672. Other information	
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675. City		676. State	
677. Zip		678. Telephone	
679. Date		680. Signature	
681. Title		682. Organization	
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713. Zip		714. Telephone	
715. Date		716. Signature	
717. Title		718. Organization	
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721. Name of the person or organization		722. Address	
723. City		724. State	
725. Zip		726. Telephone	
727. Date		728. Signature	
729. Title		730. Organization	
731. Purpose of the visit		732. Other information	
733. Name of the person or organization		734. Address	
735. City		736. State	
737. Zip		738. Telephone	
739. Date		740. Signature	
741. Title		742. Organization	
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747. City		748. State	
749. Zip		750. Telephone	
751. Date		752. Signature	
753. Title		754. Organization	
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757. Name of the person or organization		758. Address	
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761. Zip		762. Telephone	
763. Date		764. Signature	
765. Title		766. Organization	
767. Purpose of the visit		768. Other information	
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771. City		772. State	
773. Zip		774. Telephone	
775. Date		776. Signature	
777. Title		778. Organization	
779. Purpose of the visit		780. Other information	
781. Name of the person or organization		782. Address	
783. City		784. State	

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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					08293				
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN 1b 2 mos. 11 dys.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital					d. STREET ADDRESS 212 Pennsylvania Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BERTHA Middle SUZANNA Last SHIPLEY			4. DATE OF DEATH Month June Day 10 Year 19 66						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-18-76		9. AGE (In years last birthday) 89 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John M. Bush					14. MOTHER'S MAIDEN NAME Eleanor Murray				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 220-46-0257		17. INFORMANT Records, Springfield State Hospital				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4330 DUE TO Arterio-Sclerotic - C-V. Disease (b) DUE TO Bilateral Pneumonia (c) Cerebral Arterio-Sclerosis									INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Arterio-Sclerosis									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE M.C. Porterfield			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED 6-10-66			
EXAMINER'S NAME (Type) M.C. PORTERFIELD			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Address (Street, city, town, or county) Hampstead, Carroll, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/13/66		23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery		23d. LOCATION (City, town or county) (State) Westminster Md.			
24. FUNERAL DIRECTOR L. E. Myers, Jr., Westminster, Md.					25a. REC'D BY REGISTRAR JUN 13 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

08306

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08294

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.F.D. # 1M			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown d. STREET ADDRESS R.F.D. # 1M e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Fred Shoemaker			4. DATE OF DEATH June 1, 1966		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 26, 1892	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired laborer		10b. KIND OF BUSINESS OR INDUSTRY Rubber footwear		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Shoemaker			14. MOTHER'S MAIDEN NAME Mary Stuller		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-20-9118		17. INFORMANT Mrs. Ed. Ricketts, R # 1M, Taneytown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis (acute) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Arterio Sclerosis (hard) DUE TO (c) Sudden Interval Between Onset and Death Sudden Yes					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. Glenn Speicher		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 6-1-66	
EXAMINER'S NAME (Type) W. Glenn Speicher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 4, 1966		23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery	
23d. LOCATION (City, town or county) Taneytown, Maryland		25a. REC'D BY REGISTRAR JUN 3 1966			
24. FUNERAL DIRECTOR John H. Skiles		ADDRESS C.O. Fuss & Son (John H. Skiles) Taneytown, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08307

CERTIFICATE OF DEATH

08295

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>30-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>2 years 4 mos.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>3913 Fairview Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas</u> First <u>Carroll</u> Middle <u>Smith</u> Last		4. DATE OF DEATH <u>June 19</u> 19 <u>66</u> Month <u>June</u> Day <u>19</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-18-95</u> 9. AGE (In years last birthday) <u>70</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>John Smith</u>		14. MOTHER'S MAIDEN NAME <u>Julia Butler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-14-9148</u> 17. INFORMANT Address <u>Sykesville Md.</u> <u>Springfield State Hospital Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-24-64</u> , 19 <u>64</u> , to <u>6-19-66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6/19</u> 19 <u>66</u> , and that death occurred at <u>7:05 a</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Dr. Samuel Wise III</u>		22b. DATE SIGNED <u>6-19-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Samuel Wise III</u>		22d. ADDRESS <u>Springfield State Hosp. Sykesville Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 22, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>W.T. Auburn Cem. Balto Md.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Williams Funeral Home 3197 Schroeder St</u>		25a. REC'D BY REGISTRAR <u>JUN 22 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

70520

0880

342-71-515

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08308

08296

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown c. LENGTH OF STAY IN ID 24-48 hours d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown, d. STREET ADDRESS 41 York Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Walter Middle Scott Last Smith		4. DATE OF DEATH June 12 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Scott McClellan Smith		14. MOTHER'S MAIDEN NAME Carrie Belle Clutz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-32-1470	
17. INFORMANT Mrs. Walter S. Smith		Address 41 York Street Taneytown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis C.V. Disease DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
2Da. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Maurice C. Porterfield EXAMINER'S NAME (Type) Maurice C. Porterfield		22. DATE SIGNED 6-13-66 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) HARRISTEAD, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/16/66	23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery	23d. LOCATION (City, town or county) (State) Taneytown Maryland
24. FUNERAL DIRECTOR John H. Skiles John H. Skiles		25a. REC'D BY REGISTRAR J. Charles Judge 25b. REGISTRAR'S SIGNATURE J. Charles Judge	
JUN 15 1966			

00230

00230

UNITED STATES DEPARTMENT OF JUSTICE

Washington, D.C.

January 1, 1968

Dear Sir:

Enclosed for you are

three copies of a letter

dated January 1, 1968,

from the

Director

of the

Internal Security

Division

of the

Department of Justice

concerning

the

activities of the

Communist Party, U.S.A.

Very truly yours,

John Edgar Hoover

Director

Enclosure

cc: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

1968 JAN 12

U.S. DEPT. OF JUSTICE

John Edgar Hoover

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08309

08297

1. PLACE OF DEATH a. COUNTY Carroll County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millers c. LENGTH OF STAY IN 1b Box 196 Route 1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 196 Route 1				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millers d. STREET ADDRESS Box 196 Route 1 21107 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>													
3. NAME OF DECEASED (Type or print) Anton Wells Steiner		4. DATE OF DEATH Month June Day 22 Year 1966		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10.27.1890		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 06 Days 1		IF UNDER 24 HRS. Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor				10b. KIND OF BUSINESS OR INDUSTRY Plumbing and Heating				11. BIRTHPLACE (County & State, or foreign country) Annapolis, Md.				12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME Anton Steiner								14. MOTHER'S MAIDEN NAME Ann Herald									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) None				16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Gertrude B. Steiner same address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of throat - metastasis 148X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														INTERVAL BETWEEN ONSET AND DEATH 1 year			
MEDICAL CERTIFICATION																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 1/18 , 19 65 , to 6/22 , 19 66 , that (I) (we) last saw the deceased alive on 6/21 , 19 66 , and that death occurred at 8:30 PM , from the causes and on the date stated above.																	
22a. SIGNATURE D. A. Knight				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) D. A. Knight				22d. ADDRESS Greenmount Md													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6/25/1966				23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk. Cemety.				23d. LOCATION (City, town or county) (State) Elkridge, Md.					
24. FUNERAL DIRECTOR Wm. J. Fickner & Sons				ADDRESS Balto., Md.				25a. REC'D BY REGISTRAR DATE JUN 23 1966				25b. REGISTRAR'S SIGNATURE Charles Judge					

08503

08503

DEPARTMENT OF HEALTH

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

DATE: [illegible]

RE: [illegible]

BY: [illegible]

[illegible]

08503

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
08310 Items 230, 23d Film 0377 6/10/66 mh 08298											
1. PLACE OF DEATH a. COUNTY <i>Carroll</i>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Carroll County Hospital</i>						d. STREET ADDRESS <i>2017 Sandy Spring Road</i>				16-2	
3. NAME OF DECEASED (Type or print) <i>ANNIE E. TAYLOR</i>						4. DATE OF DEATH <i>June 4 1966</i>		Month <i>June</i> Day <i>4</i> Year <i>1966</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug 13, 1884</i>		9. AGE (in years last birthday) <i>81</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>P. G. Co., Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>George Doyle</i>						14. MOTHER'S MAIDEN NAME <i>Katherine Reed</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>218 20 0358</i>		17. INFORMANT <i>Milton Taylor Same as #2 (son)</i> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201 Coronary occlusion</i> DUE TO (b) <i>Chronic Myocarditis</i> DUE TO (c) <i>Hypertension</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
2Da. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Mar 26 1963</i> to <i>June 4, 1966</i> , that (I) (we) last saw the deceased alive on <i>June 4 1966</i> , and that death occurred at <i>4:15</i> M. from the causes and on the date stated above.											
22a. SIGNATURE <i>W. H. Martin</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>June 4-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>W. H. MARTIN</i>						22d. ADDRESS <i>1070 Mount Westminster Rd</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>6/7/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Johns Church Cemetery</i>				23d. LOCATION (City, town or county) (State) <i>Beltsville P. G., Md.</i>	
24. FUNERAL DIRECTOR <i>Francis Gasch's Sons Hyattsville, Md.</i>						25a. REC'D BY REGISTRAR <i>JUN 8 1966</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08311

CERTIFICATE OF DEATH

08299

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 11 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 1506 W. Mosher St.	
3. NAME OF DECEASED (Type or print) First Middle Last ARCHIE THEODORE THOMAS		4. DATE OF DEATH Month Day Year JUNE 3 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-19-31
9. AGE (In years last birthday) 34 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph M. Thomas		14. MOTHER'S MAIDEN NAME Rose Finetta	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute bilateral bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-22-66 , 19 to 6-3-66 , 19, that (I) (we) last saw the deceased alive on 6-3-66 , 19, and that death occurred at 10:00 AM from causes and on the date stated above.			
22a. SIGNATURE Octavio A. Ruiz		22b. DATE SIGNED 6-3-66	
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/7/66	
23c. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetry		23d. LOCATION (City or Town) (County) (State) Baltimore Md	
24. FUNERAL DIRECTOR Robert J. Steward		25a. REC'D BY REGISTRAR JUN 6 1966	
ADDRESS 2206 W. North St.		25b. REGISTRAR'S SIGNATURE Charles Judge	

VR A15 (4)
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DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08312

CERTIFICATE OF DEATH

08300

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville</u>				c. LENGTH OF STAY IN 1b <u>4 yrs 6 mos. 17 da</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>				07-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital Sykesville Maryland</u>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Georgianna Barrett Todd</u>				4. DATE OF DEATH Month Day Year <u>6 10 1966</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/23/76</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Ellis Barrett</u>				14. MOTHER'S MAIDEN NAME <u>Lizzie Meekins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>2-3-03-18-11</u>		17. INFORMANT Address <u>Springfield State Hospital Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome Associated with Senile Brain Disease</u>							INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-24-61</u> , 19 <u>61</u> to <u>6-10-66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6-10-66</u> , 19 <u>66</u> , and that death occurred at <u>12:40 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Alberto D. ARENGO</u>				22b. DATE SIGNED <u>6/10/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Alberto D. ARENGO, M.D.</u>				22d. ADDRESS <u>Springfield State Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/12/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>North East Meth. North East, Md.</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Grand Funeral Home</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08313

CERTIFICATE OF DEATH

08301

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester Md</u> c. LENGTH OF STAY IN lb <u>9 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Longview Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u> d. STREET ADDRESS <u>York Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARIAN HAVERLAND TUCK</u>		4. DATE OF DEATH Month Day Year <u>June 26 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 13, 1874</u> 91 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Nelson County, Virginia</u>
13. FATHER'S NAME <u>William Walker Giles</u>		14. MOTHER'S MAIDEN NAME <u>AMERICA Frances Goolsby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT Address <u>Charles Wood 4106 Mary ave</u> <u>Baltimore 6, Md</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f. (City or town) _____		(County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>May 15</u> , 19 <u>57</u> , to <u>June 26</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>June 24</u> , 19 <u>66</u> , and that death occurred at <u>2 A.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Bush MD</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>6/26/66</u>
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		22d. ADDRESS <u>Hampstead Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 28, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove E. B. Cem.</u>	23d. LOCATION (City, town or county) <u>Parkton, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u>		ADDRESS <u>New Freedom, Pa.</u>	25a. REC'D BY REGISTRAR <u>Charles Judge</u>
25b. REGISTRAR'S SIGNATURE		DATE <u>JUL 1 1966</u>	

108301

CERTIFICATE OF DEATH

108301

Form with multiple sections and fields, including checkboxes and handwritten entries. The form is oriented horizontally and contains various administrative and medical data fields.

Key sections and fields include:

- Top Section:** Contains checkboxes for "MARRIED", "SINGLE", "WIDOWED", and "DIVORCED".
- Left Column:** Includes fields for "AGE", "SEX", "RACE", "RELIGION", "EDUCATION", "OCCUPATION", "MILITARY SERVICE", "BIRTH DATE", "BIRTH PLACE", "DEATH DATE", and "DEATH PLACE".
- Right Column:** Includes fields for "CAUSE OF DEATH", "MANNER OF DEATH", "PLACE OF DEATH", "DATE OF DEATH", and "SIGNATURE OF DEATH CERTIFICATE".
- Bottom Section:** Includes a large area for "REMARKS" and a section for "SIGNATURE OF PHYSICIAN" and "SIGNATURE OF DEATH CERTIFICATE".

Handwritten entries are visible throughout the form, particularly in the "REMARKS" section and the "SIGNATURE" fields.

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08314

08302

1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER c. LENGTH OF STAY IN 1b 43 YEARS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 45 JOHN STREET		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER d. STREET ADDRESS 45 JOHN STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROY LEVI WAGNER		4. DATE OF DEATH Month JUNE Day 21 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 16, 1891
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFER		10b. KIND OF BUSINESS OR INDUSTRY RUG MANUF.	
11. BIRTHPLACE (County & State, or foreign country) CARROLL CO., MD.		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME BENJAMIN WAGNER		14. MOTHER'S MAIDEN NAME ELIZABETH FOSSETT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-03-1712	
17. INFORMANT ROBERT DOOLE REISTERSTOWN MD.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY THROMBOSIS 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASES (c) 5 YEARS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JUNE 20, 1966 to JUNE 21, 1966 that (I) (we) last saw the deceased alive on JUNE 20, 1966 , and that death occurred on JUNE 21, 1966 from the causes and on the date stated above.			
22a. SIGNATURE Daniel I. Welliver M.D.		22b. DATE SIGNED 6/21/66	
22c. PHYSICIAN'S NAME (Type) DANIEL I. WELLIVER		22d. ADDRESS 14 RIDGE ROAD WESTMINSTER MD	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 6/23/66	23c. NAME OF CEMETERY OR CREMATORY EBENEZER CEM.	23d. LOCATION (City, town or county) (State) WINFIELD CARROLL CO. MD.
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr., Westminster, Md.		25a. REC'D BY REGISTRAR JUN 23 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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of 2 copies of 1st volume of the
BRIEF HISTORY OF THE UNITED STATES
by Daniel I. Webster
1851

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08315

08303

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CITY</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SYKESVILLE</u>		c. LENGTH OF STAY IN lb <u>35</u> yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRINGFIELD State Hospital</u>		d. STREET ADDRESS <u>1512 PATAPSCO ST.</u>	
3. NAME OF DECEASED (Type or print) <u>JULIUS ALBERT WEIDNER</u>		4. DATE OF DEATH <u>JUNE 25 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 7, 1903</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRESS OPERATOR</u>		11b. KIND OF BUSINESS OR INDUSTRY	
11c. BIRTHPLACE (County & State, or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>JULIUS EDWARD WEIDNER</u>		14. MOTHER'S MAIDEN NAME <u>LOUISA SHETTLER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>HOSPITAL RECORDS</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chest Congestion (Pneumonia)</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-30</u> , 19 <u>65</u> to <u>JUNE 25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>JUNE 25</u> 19 <u>66</u> , and that death occurred at <u>4:30</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Hasson A. Salih</u>		22b. DATE SIGNED <u>6/25/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>HASSON A SALIH</u>		22d. ADDRESS <u>SPRINGFIELD State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6 29 66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Brooklyn, A. A. Co. Md.</u>
24. FUNERAL DIRECTOR <u>Mc Cully</u>		25a. REC'D BY REGISTRAR <u>JUN 28 1966</u>	
ADDRESS <u>130 E. Fort Ave.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. Name of the person or organization		2. Address	
3. City		4. State	
5. Zip		6. Telephone	
7. Date		8. Signature	
9. Title		10. Organization	
11. Remarks		12. Remarks	
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5. Zip
6. Telephone
7. Date
8. Signature
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10. Organization
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08316

CERTIFICATE OF DEATH

08304

1. PLACE OF DEATH a. COUNTY Carroll Co. MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 5yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 900 Southerly Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry Stansbury Weyrich First (W) Middle Last		4. DATE OF DEATH Month June Day 4 Year 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-4-1888 9. AGE (In years lost birthday) 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman		10b. KIND OF BUSINESS OR INDUSTRY Episcopalian	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Weyrich		14. MOTHER'S MAIDEN NAME Grace A. Stansbury	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 216-36-1162	
17. INFORMANT Address Springfield State Hosp. Records Sykesville			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE DUE TO 260x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DIABETES MELLITUS. DUE TO CBS. - ASCVD. (c)			INTERVAL BETWEEN ONSET AND DEATH DAYS YES. YES.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-17, 1961 , to 6-4, 1966 that (I) (we) lost saw the deceased alive on 6-4, 1966 , and that death occurred at 3:27 PM , from causes and on the date stated above.				
22a. SIGNATURE NACI NEWMAN BRYANT M.D.		22b. DATE SIGNED 6/4/1966		22c. PHYSICIAN'S NAME (Type) NACI NEWMAN BRYANT
22d. ADDRESS Springfield St. Hosp. Sykesville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 6/6/1966	23c. NAME OF CEMETERY OR CREMATORY Greenmount	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.		25a. REC'D BY REGISTRAR JUN 6 1966		25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06304

06316

Carroll Co.

Marshall

Calhoun

Johnson

Price

Overhill

Overhill Ave.

Overhill in State Hospital

George Washington

John

1-1-18

TY

Marshall

Overhill

Overhill

George Washington

George Washington

21-30-1821 George Washington

no

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10-10-2001 BY 60322 UCBAW/SJS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
08317					08305						
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>			c. LENGTH OF STAY IN 1b <u>5 Years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster, Md.</u> <u>06-1</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pullen Nursing Home</u>					d. STREET ADDRESS <u>153 E. Green St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Manueleeta Riggs</u>			First Middle Last		4. DATE OF DEATH <u>June 16, 1966</u>		Month Day Year				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-9-1884</u>		9. AGE (in years last birthday) <u>82</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Elisha Riggs</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth Ridgely</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. James White</u>		Address <u>Westminster, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure, Coronary</u> <u>4201</u> DUE TO (b) <u>Thrombosis, artery, Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>1965</u> <u>6-16-66</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1965</u> <u>6-16-66</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , 19 <u>66</u> , to <u>6-16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6-16</u> , 19 <u>66</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Howard E. Hall</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-16-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>					22d. ADDRESS <u>Sykesville, Maryland</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>6-18-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Glenwood Md.</u>			
24. FUNERAL DIRECTOR <u>Harry W. Knight</u>					ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

1. PLACE OF DEATH a. COUNTY CARROLL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN TB 23yrs. 4mo. 10days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		10-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NORA		First (M.) Middle (M.) Last WILHIDE		4. DATE OF DEATH Month June Day 13 Year 19 66			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-1-83	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Wilhide				14. MOTHER'S MAIDEN NAME Julia Freezy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-54-6034		17. INFORMANT Records		Address Sykesville, Springfield State Hospital, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH Minutes Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with convulsive disorder with psychotic reaction.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-3, 1943, to 6-13, 1966 , that (I) (we) last saw the deceased alive on 6-13, 1966 , and that death occurred at 10:45 AM , from causes and on the date stated above.							
22a. SIGNATURE Ilse Kamm, M.D.				22b. DATE SIGNED June 13, 1966			
22c. PHYSICIAN'S NAME (Type) Ilse Kamm, M.D.				22d. ADDRESS Springfield State Hospital Sykesville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-16-66		23c. NAME OF CEMETERY OR CREMATORY Resthaven Mem. Garden Nr. Frederick Fred. Co.		23d. LOCATION (City or Town) (County) (State) Frederick, Md.	
24. FUNERAL DIRECTOR Edward E. Weaver		ADDRESS Thurmont, Md.		25a. REC'D BY REGISTRAR JUN 15 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

08308

08310

CERTIFICATE OF MARRIAGE

Married

Married

Married

St. Louis, Mo.

St. Louis, Mo.

None

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08319

CERTIFICATE OF DEATH

08307

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Middleburg c. LENGTH OF STAY IN 1b 4 weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Brookfield Manor			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Woodsboro d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Carrie Irene Willhide			4. DATE OF DEATH Month Day Year June 3 19 66		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Sept. 7, 1893		9. AGE (In years last birthday) 72		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Frederick Co.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Edward Fogle			
14. MOTHER'S MAIDEN NAME Laura V. Keeney		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 214-28-6002		17. INFORMANT Address Mrs. Myra Dorsey Woodsboro, Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Retroperitoneal lymphosarcoma 2001 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Atherosclerotic Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH about 3 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 1966 6/2/66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1966 6/2/66 , 19 6/3/66 , that (I) (we) last saw the deceased alive on 6/2/66 , 19 6/3/66 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE J.H. Caricofe		22b. DATE SIGNED 6/3/66	
22c. PHYSICIAN'S NAME (Type) J.H. Caricofe		22d. ADDRESS Union Bridge, Md.	

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-5-66		23c. NAME OF CEMETERY OR CREMATORY Rocky Hill Cemetery		23d. LOCATION (City, town or county) (State) Nr. Woodsboro Fred. Co. Md	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager				25a. RECEIVED BY REGISTRAR DATE JUN 6 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Castell

Harryland

Weeks

Woodchuck

Proctor's Manor

Carrie Grace Williams

Sept. 7, 1897

White

Can Home

Proctor's Co.

Houswife

Edward Fogle

James V. Keaney

SM-25-6025

Woodchuck, Mo.

J. H. Carpenter

Union Bridge, Mo.

6-5-00

Serial

Rocky Hill Cemetery

Lawrence, Mo.

June 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
08320		CERTIFICATE OF DEATH	
08308			
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>1 mo. 4 dys.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore CATONSVILLE 03-2</u>		d. STREET ADDRESS <u>804 SOUTH RIDGE RD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>KARL ADOLF ZIMMERMAN</u>		4. DATE OF DEATH Month Day Year <u>June 14 19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>12-22-01</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer PIPEFITTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CAN CO.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A. Natural-ized.</u>	
13. FATHER'S NAME <u>Anton Zimmerman</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Stocker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-03-4125</u>	
17. INFORMANT <u>Records, Springfield State Hospital</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>years.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-10-66</u> , 19__, to <u>6-14-66</u> , 19__, that (I) (we) last saw the deceased alive on <u>6-14-66</u> , 19__, and that death occurred at <u>2:27 A.M.</u> causes and on the date stated above.			
22a. SIGNATURE <u>Hassan A. Salih,</u>		22b. DATE SIGNED <u>6-14-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Hassan A. Salih, M.D.</u>		22d. ADDRESS <u>Springfield State Hospital</u> <u>Sykesville, Maryland 21784</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-18-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>Stanley Cronough 57600 Indulth</u>		25a. REC'D BY REGISTRAR <u>JUN 20 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

08308

CERTIFICATE OF DEATH

08308

Name of Deceased		Date of Birth	
Sex		Race	
Marital Status		Occupation	
Cause of Death		Place of Death	
Date of Death		Time of Death	
Signature of Physician		Signature of Registrar	
Signature of Coroner		Signature of Medical Examiner	
Signature of Funeral Home		Signature of Burial Place	
Signature of Family		Signature of Friends	
Signature of Church		Signature of Community	
Signature of Government		Signature of State	
Signature of Nation		Signature of World	

RECEIVED
FEB 11 1968
U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
BUREAU OF VITAL STATISTICS
WASHINGTON, D.C. 20461